



VISN 1

DRAFT

**STAGE 2:
STRATEGIC PLAN
for FY 2006 - 2010**

**VA New England Healthcare System
Stage 2 FY 2006 – 2010 Strategic Plan**

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VA NEW ENGLAND HEALTHCARE SYSTEM (VISN 1)

STAGE 2 STRATEGIC PLAN FY 2006-2010

A. Network 1 Executive Summary

The VA New England Healthcare System is one of 21 Veterans Integrated Service Networks (VISNs) in the Veterans Health Administration (VHA). VISN 1 is an integrated health care delivery system that provides comprehensive, high quality, innovative care to the veterans it serves. Care is provided along a seamless continuum based on primary care supported by eight major medical centers in six states, 38 Community Based Outpatient Clinics (CBOCs), six nursing homes and four domiciliaries. The CBOCs located throughout New England have so improved access to care that health care delivery sites are located within 30 miles of 97% of the veterans served in New England.

Network 1 serves over 231,000 veterans with a total budget of over \$1.3 billion. Medical centers currently operate 1,930 inpatient beds for acute medical/surgical, mental health, nursing home and domiciliary care. Annually Network 1 has over 26,000 admissions and over 2.3 million outpatient visits. As of September 2004, Network 1 increased the number of patients served over the previous twelve months by 3.2% to approximately 231, 000 patients (approximately 19% of veterans in New England.) Future needs require balancing a decreasing number of patients with increasing demands for geriatric and extended care due to advancing age.

Network 1 is the largest health care provider in New England. Affiliated medical schools include: Boston University, University of Connecticut, Brown University, University of Massachusetts, Dartmouth College, University of Vermont, Harvard University, Yale University, and Tufts University.

As an integrated health care delivery system, the VA New England Healthcare System has adopted the service line approach to health care delivery. Based on an analysis of the major health care services used by veterans in New England, health care delivery was organized around five core categories of care: Primary Care, Specialty and Acute Care, Mental Health Care, Spinal Cord Injury Care and Geriatrics and Extended Care. These programs are integrated across the Network to enhance quality of care through consistent standards of care, better coordination of care and quality benchmarks. In addition, four support service lines were formed consisting of: Information Management, Local Management at the eight medical centers, Business Office, and Sensory and Physical Rehabilitation Services. The interrelationships of these nine service lines are a major factor in ensuring the transition toward an integrated network of coordinated quality care.

Improved access to care, enhanced patient outcomes, and patient and employee satisfaction will remain key goals. Network 1 stands among the top three networks on performance measure achievement, is a leader in customer satisfaction results and is committed to becoming a Baldrige organization.



VISN 1 fully supports the newly adopted **VHA Mission Statement**: to “Honor America's veterans by providing exceptional health care that improves their health and well-being.” Network 1 also supports the **VHA Vision Statement**: “To be a patient-centered integrated health care organization for veterans providing excellent health care, research, and education; an organization where people choose to work; an active community partner; and a back-up for National emergencies.” Network 1's **Core Values** are:

*Trust ✕ Excellence ✕ Respect
Compassion ✕ Commitment*

Our **Key drivers** are: achieve excellence in clinical care, education, research, employee development and satisfaction, fiscal solvency, and management. Our strategic goals are linked to the Network mission and receive appropriate high priority attention across the organization.

The planning process evolved from experiences gained from participation in the Capital Asset Realignment for Enhanced Services (CARES) planning process that began in 2002. The planning structure now in place includes a steering committee and four geographic market teams: Far North (Maine), North (New Hampshire and Vermont), West (western Massachusetts and Connecticut), and East (eastern Massachusetts and Rhode Island). Markets were determined based on geography, historical referral patterns and population factors.

Network senior leaders create an environment for empowerment, innovation and organizational and employee learning through a culture of continuous improvement of the service line structure and two-way communication of the Network's strategies and results. The Executive Leadership Board (ELB) follows a planning sequence throughout each year to set short- and long-term goals and monitor progress in light of changing conditions.

The Strategic Planning Committee (SPC) is composed of the market team leaders and representative service line directors, stakeholders, Network staff, and medical center directors. The SPC coordinates overall planning, provides guidance to market teams, service lines and medical centers and ensures consistency of approaches to Network-wide

issues. Goal planning horizons were chosen primarily to correspond to the annual availability of VHA performance data, recognition of the time required for major program changes to be fully implemented, the ability to forecast market changes, and the time needed to plan for capital improvements.

The strategic planning framework for the New England Healthcare System was designed to ensure that the broad mission and goals of VA are translated into meaningful goals, measurable outcomes, and effective operational plans. The strategic plan is based upon the VHA FY 2006-2010 goals and strategies. Profound changes will occur in the Network health care system with the implementation of the key strategies. These eight strategies are described with a summary of the VISN plans for implementation. Network 1 is committed to providing leadership and resources to achieve excellence in all these key strategies.

In addition to the VHA strategies and initiatives, the Executive Leadership Board approved four high priority goals for VISN 1 for 2006. These Network goals were based on an analysis of data and the expert assessment of Network senior leaders. The VISN 1 priority initiatives listed below align closely to VHA priority strategies and initiatives and will improve the delivery of health care to veterans across the Network. Each priority goal has a specific action plan developed with a dedicated champion, measures of performance, timelines, expected levels of performance, and a process for reporting progress. The four priority goals are:

- Expansion of Coordination of Care programs;
- Improve integration of the Specialty and Acute Care service line;
- Advancement of Mental Health programs; and
- Maintain fiscal solvency.

VHA strategies have also been assigned to dedicated champions using the same process. The Network service line organization, by its nature and scope of responsibility, ensures that priority goals are deployed consistently Network-wide and that changes are incorporated into on-going operations, so performance is sustained and improved.

Recent statutory changes in VHA eligibility, the closing of local HMOs, the cost of prescription medications and, more recently, the war on terror have all contributed to an increased demand for services as shown by a 43% growth in veterans served since 1996. In the recent past, medical centers had to hire staff, renovate vacant space, lease additional space, and rely on contract and locum tenens providers to meet growing needs, especially for primary care. In the short-term, the Network must expect increases in referral for specialty care and increases in the need for long-term care and continuing care. The Network Workforce Succession Plan includes identification of the associated staffing needs and action plans. The Network Human Resources and Workforce Succession Plans serve as action plans in support of goals and other initiatives.

Mental Health Summary

Several positive gaps were identified in the Far North Market and North Market as well as for Domiciliary (DOM) and Psychosocial Residential Rehabilitation Treatment Program

(PRRTP) in the VISN that met defined criteria and reached the required threshold. These included “Mental Health Inpatient Programs” for the Far North Market and “Other Mental Health Inpatient Programs: for the North Market. Negative gaps were found in the West and East Markets. These included “Ambulatory: Behavioral Health” for the West Market and “Inpatient Psychiatry and Substance Abuse” along with “Other Mental Health Inpatient Programs: for the East Market.

Based on guidance provided by VA Central Office, all issues affecting the Boston area facilities were deferred, pending the completion of the CARES Boston Study. The data supports a reduction of beds in the East Market. However, Providence is the only facility in the East Market outside of the Boston area and has no beds in the category, “Other: Mental Health Inpatient Programs,” and has only 17 psychiatry beds for veterans who live in the State of Rhode Island. Therefore, it was decided that no actions would be identified for the East Market to address the identified negative gaps.

VISN 1 has historically recognized that Vermont, New Hampshire and Maine had fewer mental health programs than the East and West Markets. This Plan is designed to address the imbalance of mental health resources among markets in the VISN. In VISN 1, the model indicates the need to close beds in the East Market while establishing beds in the North and Far North Markets.

In order to address the gap in the Far North Market in the “Other: Mental Health Inpatient Programs”, it is proposed that a 25-bed Substance Abuse Residential Rehabilitation unit be established at Togus and a 25-bed Substance Abuse Compensated Work Therapy Treatment (CWT/TR) program be established in Portland.

In order to address the gap in the North Market in “Other: Mental Health Inpatient Programs”, it is proposed that an 18-bed Long Term Psychiatry unit and a 15-bed SA CWT/TR program be established at Manchester. In addition, a 15-bed Substance Abuse Residential Rehabilitation unit is proposed for White River Junction.

In order to address the VISN-wide gap of 105 Dom & PRRTP beds in 2013 and 49 beds in 2023, it is proposed that a 25-bed Domiciliary be established at Togus and a 25-bed Domiciliary be established at the West Haven campus of VA Connecticut.

To address the negative gap in Ambulatory: Behavioral Health in the West Market, planned decreases will occur based on demographics. These will be distributed to Newington, West Haven, and Northampton to account for the required reduction in stops by 2013.

CARES Summary

A systematic assessment of capital assets infrastructure took place in Network 1 through the CARES process. This process was a data driven assessment of veterans’ health care needs within Network 1 and the strategic realignment of capital assets and related resources to better serve the needs of veterans. Market plans were developed for the four Markets within the Network and integrated into a Draft National CARES Plan by the Office of the VHA Undersecretary for Health. This plan was then submitted to an independent

CARES Commission comprised of non-VA executives appointed by the Secretary who conducted site visits, held public hearings and reviewed supporting data to develop recommendations to the Secretary. The Secretary considered the CARES Commission's recommendations prior to making his final decision on the National CARES plan in May 2004.

The Secretary's May 2004 decision on the CARES study marked a three-year review of veterans' current health care needs and recommendations for meeting those needs in the future. The Secretary's Decision document identified 18 VA Medical Centers needing further study. Boston is one of the 18 study sites. During Stage II of CARES, the consulting firm of PricewaterhouseCoopers is performing additional CARES Business Plan Studies for these sites with an expected completion date of March 2006.

As a result of the Secretary of Veterans Affairs May 2004 CARES decision, the Department of Veterans Affairs recently appointed a Local Advisory Panel (LAP) to assist VA in gathering information on the VA Boston Healthcare System and the Edith Nourse Rogers (Bedford) VAMC as part of the next phase of the CARES process. This panel will identify and evaluate options for the delivery and location of services for providing care to veterans now treated at the Jamaica Plain, West Roxbury, and Brockton campuses of the VA Boston Healthcare System, and the Bedford VAMC. CARES also includes a series of construction and renovation projects to improve the aging infrastructure and to meet projected patient care demands for the next 20 years. Development of care coordination/home telehealth plays an important part in meeting these new system demands. Analysis of past and projected workload was undertaken as part of the CARES process, resulting in supply, demand and gap analysis. As a result, options for initiatives to close gaps and meet demand are proposed. Included are patient care needs by medical category.

VISN 1 sized its capital projects to the FY 2023 projections to avoid overbuilding to the peak. Interim peaks in workload will be met by alternatives such as contracting out and leasing.

The Network 1 CARES Plan includes capital needs driven by the CARES process as well as those reflecting the need to upgrade aging infrastructure. The size, scope and location of projects were based on several assumptions:

- Projected workload numbers used to size projects were for FY 2023. Any peaks occurring during the interim would be accomplished by options other than construction.
- Access sites were located to achieve a minimal 70% threshold level for calculated drive times. With few exceptions they were located in areas that were felt to meet minimum demographic criteria as outlined in VA guidelines for establishing CBOCs.
- To the extent feasible, workload was "offloaded" to new and existing CBOCs to improve travel times for patients and also reduce the size of the capital projects on campus. One additional CBOC and five outreach clinics are planned to add additional capacity outside the medical centers in Primary Care and Mental Health.

- The model used in the CARES process projects FY 2023 enrollment levels below current levels for all Markets.

Appendix A includes the Network's plan for Capital Asset Planning.

B. Verification of Stage I Information

The following table summarizes the Stage I strategies and identifies any major variations from the findings presented in the Stage I Strategic Plan for VISN 1.

VHA STRATEGIC OBJECTIVES	VHA STRATEGIES	STATUS
1. Lead the nation in health care for patients with disabilities.	1.1 VISN 1 capabilities to provide the full continuum of care for visually impaired veterans. 1.2. Evaluate VISN 1 capabilities to provide the full continuum of services in the amputation care program.	On track On track
2. Maximize recovery of patients with mental health conditions	No major variations noted.	On track
3. Provide a seamless transition from military to VA health care.	No major variations noted.	On track
4. Promote timely and equitable access to health care.	4.1. Establish in each VISN and each medical center an Advanced Clinic Access (ACA) Steering Committee or similar leadership Structure whose responsibility is to coordinate the implementation of ACA. 4.2 Identify in each VISN two key roles. 4.3 Hold at least one VISN wide sustained learning opportunity such as learning collaborative. 4.4 Demonstrate by VISN that resource allocation requires evidence of implementation of ACA prior to decision-making. 4.5 Each medical center will identify high-risk conditions and will implement ACA principles including process mapping and flow analysis to eliminate delays in the entire process of diagnosis and treatment.	On track
5. Continuously improve the quality and safety of health care.	Ensure full compliance with VHA residency supervision policies. Improve development and implementation of Clinical Practice Guidelines. Ensure the safe administration of medication, including the deployment of the redesigned Bar Code Medication process. Improve or sustain performance of preventive health measures and monitors, including diabetic retinal screening and influenza.	On track

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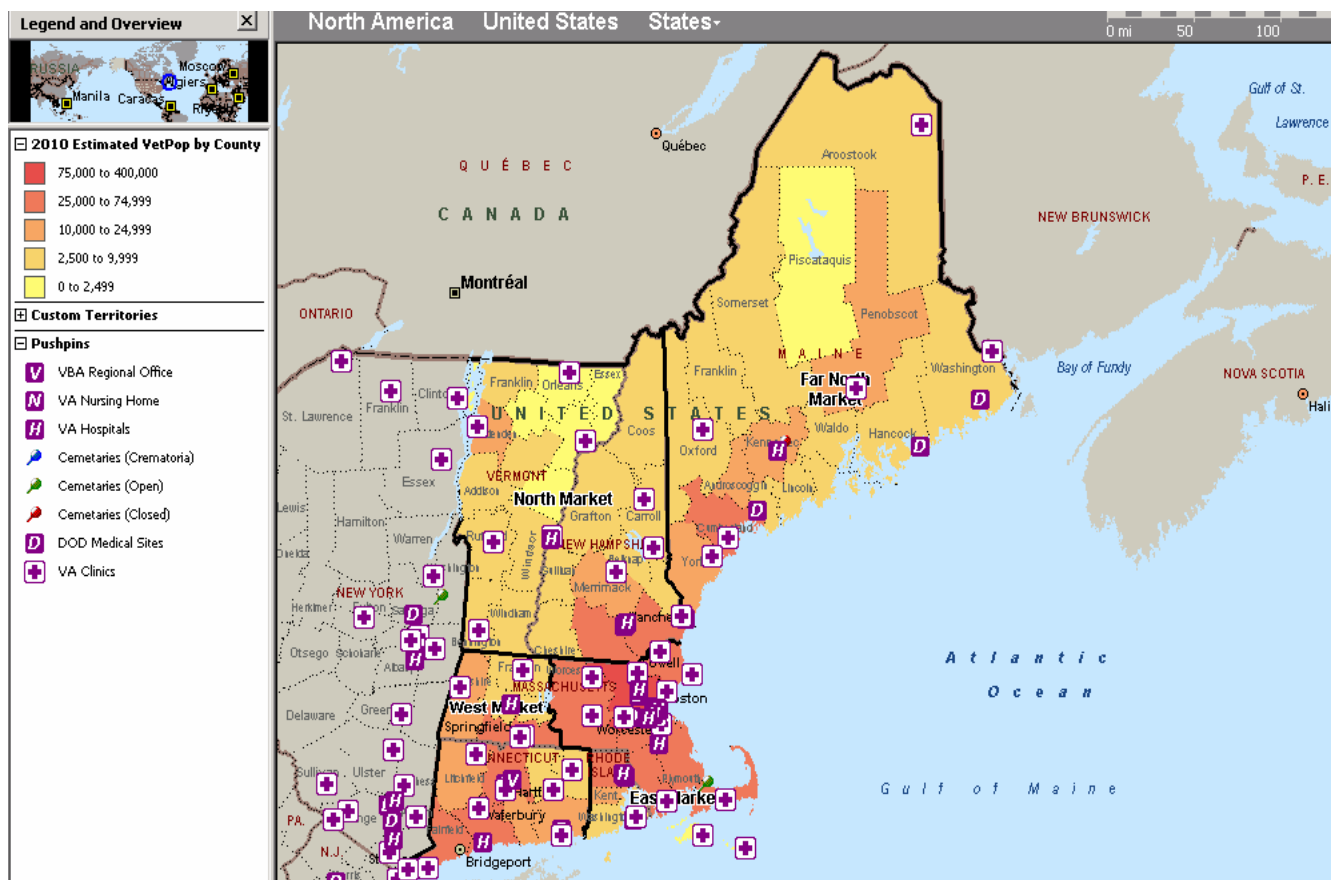
6. Care Coordination	6.1 Fully implement Care Coordination Program and achieve a census of 500 cc/ht patients per designated VISN as identified by the end of FY 2005.	Some delay in full program implementation due to equipment acquisition delays and appointment of key staff in some locations.
	6.2 Fully implement the VISN operation plans for Indian Health Service	On track
7. Proactively invite and act on complaints and suggestions	7. Each VISN to develop and initiate one new approach to proactively initiate customer service feedback.	On track
8. Equip patients and staff with practical Health Information	Fully implement data standardization efforts for 12 established domains. Fully implement MyHealthVet. Through combining essential health record information with online health resources to enable and encourage veteran/clinician collaboration. Increase collaboration among VHA, VBA and DOD. Implement the electronic support for Patient Decision Initiatives to create a standardized approach to informed consent and related decision making.	On track
9. Focus Research Efforts on Veterans Special Health Care Needs	No major variations noted.	On track
10. Promote Excellence in the education of Future Health Care Professionals	Maximize debt reduction programs Maximize use of existing discretionary programs such as recruiting programs Optimize educational milieu Promote enhance career development Foster technological innovations to meet expectations of recently trained health care professionals.	On track
11. Assure VHA's readiness to respond incase of local and national emergencies	Provide technical assistance and support CEMP Provide decontamination training Achieve 100% participation of VA facilities in DEMPS Emergency drug caches are properly maintained at all VA health care facilities designated to have such programs	On track
12. Match VHA's Human Resources with current and future staffing needs	Implement the Nursing Commission Report Complete implementation of LMS Expedite implementation of Title 38	On track in most areas

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	<p>Refine and expand employee development program</p> <p>Explore additional methods for improving retention of experienced staff</p>	
13. Enhance the work environment	<p>13.1 Establish Human Resources Management Group composed of HR Leads</p> <p>Develop and implement a plan that defines specific VISN and program office action.</p>	On track
14. Raise Awareness of VHA and Services Provided	<p>Each VISN should develop a field based program to enhance awareness of VHA services</p> <p>Develop a toolkit of communication strategies</p>	On track
15. Increase Revenue and Efficiency Through Sound Business Practices	<p>Increase revenue and efficiency through sound business practices</p> <p>Ensure full compliance with VA physician time and attendance</p> <p>Continue implementation of Procurement Task Force Recommendations</p> <p>Continue revenue cycle improvement initiatives</p> <p>Implement Federal Shared Third-Party Obligation Program</p> <p>Networks will continue to work with DoD</p>	On track in most areas

C. Socio-Demographic Information

New England is a large geographic area that spans the full spectrum of socioeconomic conditions from dense, urban centers to sparsely populated rural areas. Network 1 health care is delivered through an integrated system of eight hospitals and 38 community-based outpatient clinics. Within Network 1, there are four CARES Markets: Far North (Maine); North (Vermont and New Hampshire); West (Massachusetts west of Worcester County and all of Connecticut); and East (Eastern Massachusetts, including Worcester County and all of Rhode Island.)



SOURCE: VSSC Data Cube, "Utilization by VISN & Market."

For purposes of forecasting demand 20 years into the future, enrollment projections for the development of the FY2006 – 2010 strategic plan took into consideration both utilization rates and enrollment by geographic area, age, gender and priority groups. The model attributes are such that any of the underlying assumptions are readily adaptable to change (e.g. policy decisions, shifts in population, covered benefit and copay structures, degree of health care management, morbidity, enrollment, etc.)

Total Number of Counties by State and Market: VISN 1

State	Total Counties in State	Total Counties in VISN	Total Counties in Market			
			East	Far North	North	West
Connecticut	8	8	0	0	0	8
Maine	16	16	0	16	0	0
Massachusetts	14	14	10	0	0	4
New Hampshire	10	10	0	0	10	0
Rhode Island	5	5	5	0	0	0
Vermont	14	14	0	0	14	0
Total	67	67	15	16	24	12

**Counties Designated as Medically Underserved Areas/Populations
by State and Market: VISN 1**

State	Designated Counties in State	Designated Counties in VISN	Designated Counties in Market			
			East	Far North	North	West
Connecticut	8	8	0	0	0	8
Maine	16	16	0	16	0	0
Massachusetts	12	12	8	0	0	4
New Hampshire	10	10	0	0	10	0
Rhode Island	5	5	5	0	0	0
Vermont	13	13	0	0	13	0
Total:						
Number	64	64	13	16	23	12
Percent	95.5%	95.5%	86.7%	100.0%	95.8%	100.0%

SOURCE: U.S. Dept. of Health & Human Services, Bureau of Primary Health Care, "Medically Underserved Areas/ Medically Underserved Populations," located at <http://bphc.hrsa.gov/databases/newmua/>. Run date October 7, 2004. "Health Professional Shortage Areas" can be found at <http://belize.hrsa.gov/newhpsa/newhpsa.cfm>.

**Counties with 2002 Per Capita Income (PCI) Below \$25,000
by State & Market: VISN 1**

State	Counties in State with PCI <\$25K	Counties in VISN with PCI <\$25K	Counties in Market with PCI <\$25K			
			East	Far North	North	West
Connecticut	0	0	0	0	0	0
Maine	7	7	0	7	0	0
Massachusetts	0	0	0	0	0	0
New Hampshire	0	0	0	0	0	0
Rhode Island	0	0	0	0	0	0
Vermont	5	2	0	0	2	0
Total:						
Number	12	9	0	7	2	0
Percent	17.9%	13.4%	0.0%	43.8%	8.3%	0.0%

SOURCE: U.S. Dept. of Commerce, Bureau of Economic Analysis, "County Summary Table CA1-3: 1969 - 2002," located at http://www.bea.gov/bea/regional/reis/ca1_3.cfm. Run date October 1, 2004.

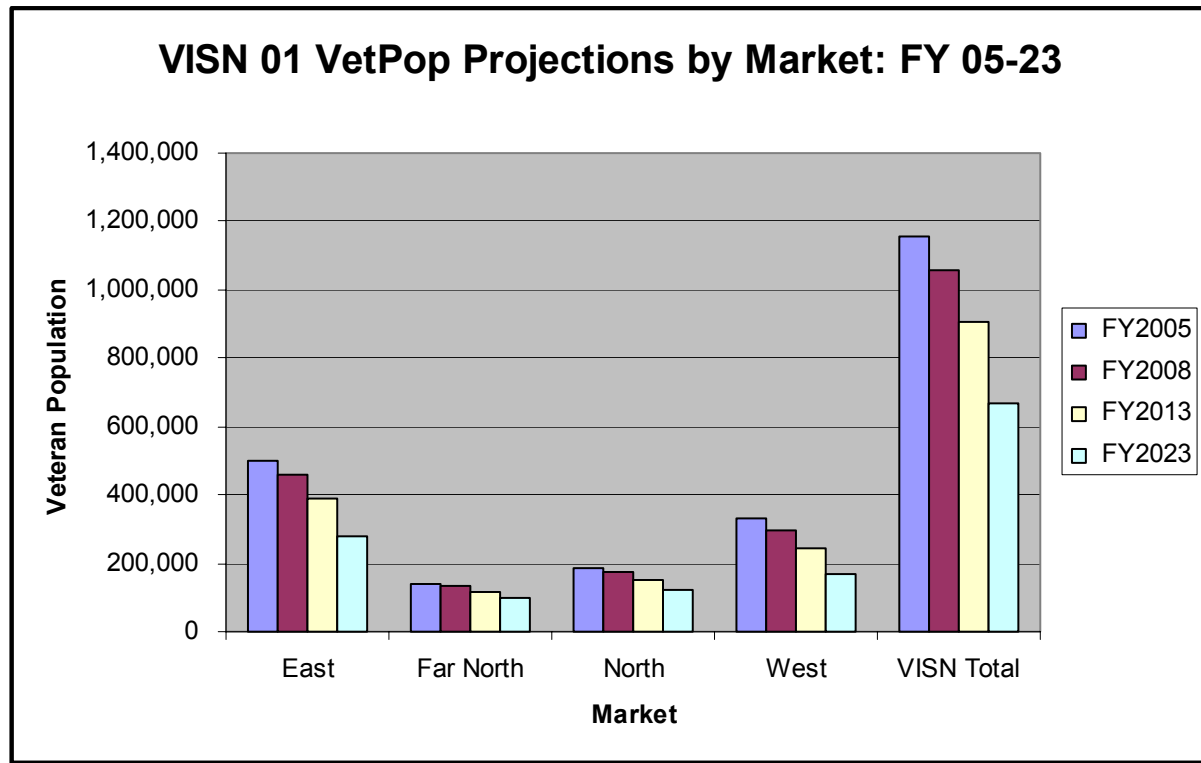
Currently, an estimated 1.2 million veterans reside in New England. However, the New England states have experienced a decline in overall veteran population in recent years, and population models indicate that the veteran population will decline over the next 18 years as World War II era veterans reach end-of-life. The veteran population in VISN 1 is expected to decrease by 42% from the FY2005 level to FY2023. Despite projections of decreasing numbers of New England veterans, Network 1 experienced an increase in outpatient visits and the overall number of veterans served in FY2004.

**Table : VISN 01 Veteran Population Projections by
Market: FY2005 - 2023**

Market	Fiscal Year				% Change between FY05 & FY23
	FY2005	FY2008	FY2013	FY2023	
East	501,518	457,571	386,524	278,853	-44.4%
Far North	140,029	131,925	118,839	96,498	-31.1%
North	183,176	172,287	153,777	121,089	-33.9%
West	331,410	298,299	246,629	170,795	-48.5%
VISN Total	1,156,133	1,060,083	905,769	667,235	-42.3%

Source: VSSC Data Cube, "Enrollment_Veteran Population Projections 02-22-05".

As noted below in the VetPop Projections by Market, future population projections indicate the overall number of veterans is expected to decline in all Markets. The most significant decrease from 2005 to 2023 occurs in the East Market.



In looking at population trends on a national basis, each of the four age groups is projected to decrease with the exception of the smallest age group, 85+, which is expected to increase. This is due mainly to the veteran population getting older and a lower number of new veterans coming into our system. As shown in the table below, the VISN 1 veteran population trend is similar in that a 22% decrease is projected for all age groups between 2005 and 2013, and a 42% decrease from 2005 to FY2023. The exception in declining numbers occurs in the group of veterans who are older than 85. For the 85+ group in VISN 1, a 47% increase is projected between FY 2005 and FY 2013, with an overall 5% increase between FY 2005 and FY 2023.

Despite the decreasing size of the veteran population, demand for benefits and services is projected to increase as the veteran population ages. This scenario presents many challenges because older veterans typically require more care as well as more expensive care. The Network 1 Strategic Plan recognizes this future demand and includes several strategies for meeting the needs of the aging veteran population.

Female veterans comprise the fastest growing segment of the veteran population as demonstrated in the population projections by gender. In the 45-64 age group, the female veteran population will increase steadily in the four markets, peaking in 2013 and then declining by 2023. The exception is the Far North market, where this age group will continue to increase. Within VISN 1, despite the large decrease in total veteran population, the female veteran population is relatively stable across the planning horizon as evidenced by a minimal decrease of 1.47% between FY2005 and FY2023.

The Far North, North, West and East markets all show lower enrollment projections in FY 2023 than in FY 2005. As outlined in the Executive Summary, VISN 1 sized its capital projects to the FY 2023 projections to avoid overbuilding to the peak. Interim peaks in workload will be met by alternatives such as contracting out and leasing.

Table: VISN 01 Veteran Population Projections by Market, Age and Gender: FY2005 – 2023

Market	Age	Gender	Fiscal Year			
			FY2005	FY2008	FY2013	FY2023
East	< 45	Female	10,613	9,181	7,947	7,934
		Male	69,049	57,039	43,804	38,700
		< 45 Total	79,662	66,219	51,751	46,635
	45 - 64	Female	9,253	11,156	12,879	11,811
		Male	187,427	169,907	125,661	74,691
		45 - 64 Total	196,680	181,063	138,540	86,502
	65 - 84	Female	7,442	5,246	4,308	6,363
		Male	197,132	177,751	162,246	118,594
		65 - 84 Total	204,574	182,998	166,555	124,957
	85+	Female	1,881	2,952	2,324	949
		Male	18,720	24,339	27,354	19,811
		85+ Total	20,602	27,291	29,678	20,760
	East Total		501,518	457,571	386,524	278,853
Far North	< 45	Female	4,394	4,147	4,049	4,343
		Male	25,380	22,689	19,869	19,048
		< 45 Total	29,774	26,836	23,919	23,390
	45 - 64	Female	3,105	3,815	4,563	4,625
		Male	56,347	52,927	41,462	27,025
		45 - 64 Total	59,452	56,742	46,025	31,649
	65 - 84	Female	1,740	1,375	1,289	2,073
		Male	45,012	41,607	41,540	34,528
		65 - 84 Total	46,752	42,982	42,829	36,601
	85+	Female	354	544	440	261
		Male	3,697	4,821	5,627	4,596
		85+ Total	4,051	5,365	6,067	4,857
	Far North Total		140,029	131,925	118,839	96,498
North	< 45	Female	5,036	4,632	4,362	4,587
		Male	32,392	27,819	22,721	20,874
		< 45 Total	37,428	32,451	27,083	25,461
	45 - 64	Female	4,137	4,969	5,818	5,627
		Male	76,823	71,907	56,081	35,045
		45 - 64 Total	80,960	76,876	61,899	40,671
	65 - 84	Female	2,608	2,090	1,859	2,717
		Male	57,291	54,269	55,233	45,941
		65 - 84 Total	59,899	56,359	57,092	48,658
	85+	Female	487	763	647	380
		Male	4,402	5,839	7,055	5,918
		85+ Total	4,889	6,602	7,702	6,298
	North Total		183,176	172,287	153,777	121,089

Table: VISN 01 Veteran Population Projections by Market, Age, and Gender: FY2005 – 2023 - Continued

Market	Age	Gender	Fiscal Year			
			FY2005	FY2008	FY2013	FY2023
West	< 45	Female	7,090	6,214	5,568	5,699
		Male	43,256	35,789	28,705	26,283
		< 45 Total	50,346	42,002	34,273	31,983
	45 - 64	Female	6,142	7,113	7,907	6,917
		Male	127,406	111,570	76,778	41,718
		45 - 64 Total	133,548	118,683	84,685	48,634
	65 - 84	Female	4,423	3,219	2,709	3,868
		Male	129,826	116,754	105,556	73,145
		65 - 84 Total	134,249	119,972	108,265	77,012
	85+	Female	1,064	1,696	1,337	588
		Male	12,203	15,946	18,069	12,578
		85+ Total	13,267	17,642	19,406	13,166
	West	Total	331,410	298,299	246,629	170,795
VISN Total		1,156,133	1,060,083	905,769	667,235	

As indicated in the table below, the number of eligible enrollees in Priority groups 1 thru 6 is projected to increase slightly from 220,000 in 2005 to a peak of approximately 233,000 in 2008. However, a 13% decrease then occurs in Priority groups 1-6 by 2023, and a 32% decrease for all Priority groups. The most significant decline occurs in Priority group 7 and 8's.

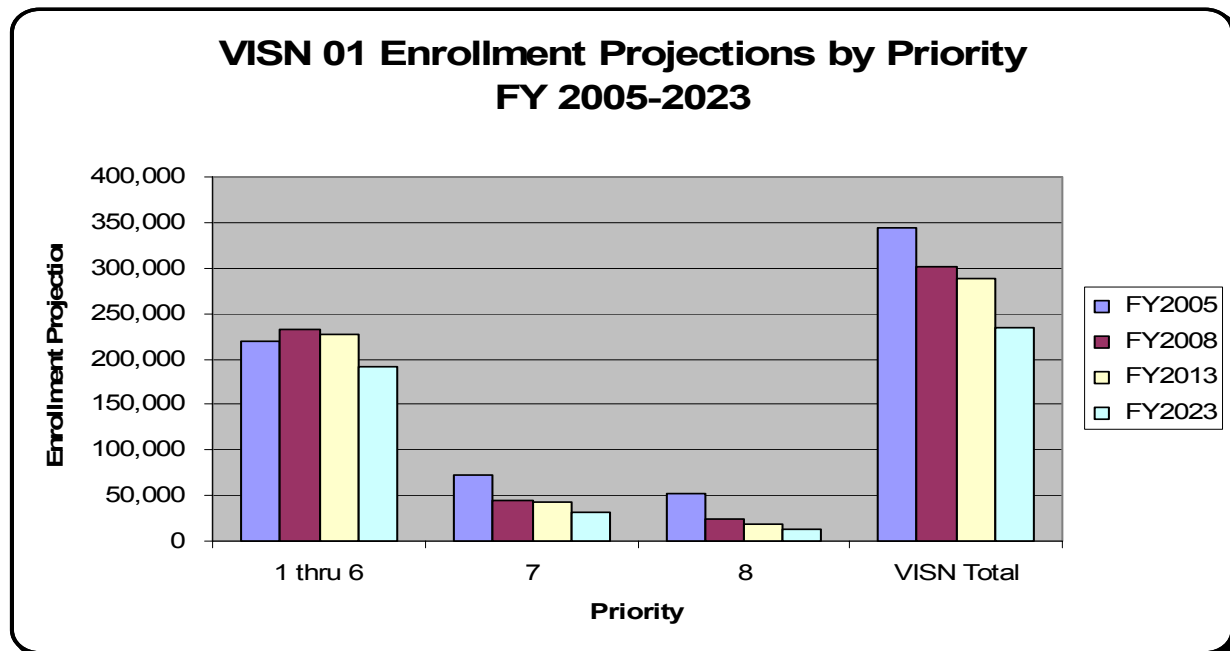
Table : VISN 01 Enrollment Projections by Priority: FY2005 - 2023

Priority	Fiscal Year				% Change between FY05 & FY23
	FY2005	FY2008	FY2013	FY2023	
1 thru 6	220,076	233,012	227,417	190,983	-13.2%
7	72,377	44,757	43,285	32,119	-55.6%
8	52,159	23,415	17,888	12,225	-76.6%
VISN Total	344,612	301,183	288,590	235,326	-31.7%

Source: VSSC Data Cube, "Enrollment_Veteran Population Projections 02-22-05".

**Table : VISN 01 Enrollment Projections by Market
and Priority: FY2005 - 2023**

VISN	Market	Priority	Fiscal Year			
			FY2005	FY2008	FY2013	FY2023
1	East	1 thru 6	94,848	99,316	97,220	80,338
		7	30,976	19,129	19,463	14,281
		8	15,366	6,953	5,639	3,964
		Total	141,191	125,398	122,323	98,583
	Far North	1 thru 6	33,018	35,602	36,006	32,086
		7	3,254	2,113	2,395	2,391
		8	10,884	4,920	3,881	2,800
		Total	47,157	42,634	42,282	37,277
	North	1 thru 6	35,872	38,222	38,198	33,631
		7	8,493	5,435	6,163	5,461
		8	11,296	5,054	4,016	2,692
		Total	55,661	48,711	48,376	41,783
	West	1 thru 6	56,338	59,872	55,993	44,927
		7	29,653	18,080	15,264	9,986
		8	14,612	6,488	4,352	2,769
		Total	100,604	84,440	75,609	57,683
	VISN Total		344,612	301,183	288,590	235,326



Source: VSSC Data Cube, "Enrollment_Veteran Population Projections 02-22-05"

D. Narratives

VHA Strategies: Aligning 15 strategies for FY 2006-2010 with New VHA Strategies

VISN 1 operational goals, strategies, and initiatives are aligned with the new VHA Strategies as outlined below.

Strategy 1. Continuously improve the quality and safety of health care for veterans, particularly those health issues associated with military service.

1a. Intensive Care Unit (ICU) Quality Improvement Project:

- ICU Technical Advisory Group (TAG) recommendations are being addressed; admission criteria being standardized; diversion policies in place; ACLS certification for RNs & MDs progressing.

1b. Institute for Healthcare Improvement (IHI) 100,000 Lives Campaign.

- Network 1 is committed in concept to the 100,000 Lives Campaign and is waiting further guidance from VACO.

1c. Ongoing development of poly-trauma centers

- Identify resources needed for a Level II Tertiary Polytrauma Center in VISN 1 (i.e., Boston HCS). A Level II facility will provide a high level of expert care, a full range of clinical and ancillary resources, and serve as a resource to other facilities within VISN 1.

1.2 Fully implement VA's personal health record, My HealthVet (MHV)

The Network successfully implemented Phase I in November 2003 with the distribution and installation of MHV personal computers in every facility. The Network successfully implemented Phase II in November 2004 with a communication plan to veterans throughout the region. Using information from the national MHV portal, the number of "hits" to the My HealthVet website from states within New England has steadily increased since November 2003 and substantially after Phase II.

Functionality for MHV planned for release in August 2005 includes ability of veterans to refill medications via the web portal. This new function will substantially add to the attractiveness of the site for the veteran patient.

Continuing actions include:

- Plan communication strategy timed with the August 2005 Pharmacy Refill enhancement
- Engage stakeholders in communication plan to include Primary Care Service Line, Pharmacy, and Primary Care Telephone Care.
- Communication tools for doctors, pharmacists, other providers to hand to patients and engage in discussion about MHV
- Communication tools for group teaching in clinic by clinic support staff

- Study impact of communication plan by tracking MHV web “hits” and Primary Care Telephone Care call volume related to pharmacy issues.

1.3 Advance the transition to VA's next generation electronic health record, HealthVet-VistA (VistA 2.0).

The Network has been successful in implementing data standardization in support of HDR (Health Data Repository). HDR represents the first step towards the re-engineered HealthVet-VistA. Our network identified the VISN 1 HDR coordinator and this person established the HDR teams and points of contact for each facility. This group has met regularly with the national implementation team. Our network has installed 100% of the required software patches. National HDR scorecard information shows the Network well on track with HDR data standardization in the domains of Allergens, Drug Names, Lab Tests and ICNs.

Additional accomplishments of Network 1 include:

- first network to turn on VISTA data transmission triggers for all facilities and transmit data continuously to Austin
- participated in testing and validating of Vitals data transmission (VA Connecticut)
- Fully implement re-engineered packages when released – e.g. - Care Management

The involvement of Network 1 and VA Connecticut was critical in meeting the national milestone of standardizing the Vitals information in July 2005. Data loss during transmission was occurring and VISN 1 expertise with Cache SQL and the willingness of VISN 1 HDR points of contact to work with the national HDR team was instrumental in solving these problems.

VISN 1 is also participating in the Northeast RDPC demonstration project. This project involves VISN 1 through VISN 4 and will test hardware configurations capable of hosting the future HealthVet software. This demonstration project will establish a regional data processing center (RDPC) robust enough to run 4 networks along the Northeast corridor. This testing of platform and architecture will be critical in the national deployment of the re-engineered electronic medical record. A RDPC Northeast Demonstration Project team has been identified and has already begun work with the teams from Networks 2, 3, and 4.

Continuing actions include:

- Network 1 HDR coordinator and facility teams will continue to work on national project milestones for data standardization
- Next phases (HDR-historical and HDR-II) project teams to be implemented
- RDPC Northeast Demonstration Project team will continue work on testing hardware platforms capable of running the re-hosted VistA on a regional scale.

1.4 Implement the recommendations of the comprehensive mental health strategic plan regarding substance abuse, PTSD, Seriously Mentally Ill (SMI), CBOCs, telehealth, care coordination and homelessness. (**See Part A**).

1.5 Pursue innovations in services to aging veterans that enhance VA capabilities in Long Term Care including care coordination and telehealth technologies to include:

- Continued capital support of Home Based Primary Care (HBPC) is one of Geriatrics and Extended Care's (GEC) continuing goals. The GEC service line will continue to pursue the development of HBPC programs in the VISN 1 facilities that have yet to implement programs and attempt to further expand those programs currently operating.
- The GEC service line will explore the development and further use of home telehealth technologies through promotion and implementation of research projects to determine future strategies for the realization of maintaining our veterans in the least restrictive environment.
- GEC will implement the "GEC Referral" tool, once released by VA Central Office, to facilitate the appropriate assessment and care for elderly veterans seeking geriatrics services.
- The improvement of end of life care for aging veterans is a principal interest of this service line. Over the next year they will work to improve our programs in this area. The establishment of Veterans hospice partnerships with community agencies is well on the way in Maine and Massachusetts. Opportunity exists in other New England states and the model is easily exportable. In addition, expansion of inpatient hospice care will be addressed within the current Nursing Home Care Unit (NHCU) bed capacity.
- GEC will continue to advocate for the efficient effective use of capital funds by maintaining the census of staffed nursing home beds, maximizing the Average Daily Census (ADC) in VA operated programs and husbanding resources for community nursing home beds.
- Expansion of home and community-based care will continue to be a goal for those veterans who have an assessed need.
- Education of staff across service lines to facilitate the coordination of care and implementation of home telehealth technologies is a continuing goal. We will work with all service lines in a collaborative effort to increase the number of patients whose care is being managed through the use of in home technology.

Strategy 2 – Provide Timely and appropriate access to health by implementing best practices

1. Implement Advanced Clinic Access (ACA)

- VISN 1 plans to hold a workshop in collaboration with Executive Leadership Board, Clinical Leadership Committee and Quality management representing VISN Senior Leadership. This workshop will also include identified Station Champions, VISN coaches and selected members of the VISN Steering Committee. The Goal of this workshop will be; development of a Station Plan for ACA spread which include Senior Leadership, Champions and the local Steering Committee.

We will utilize VISN 1 National Coaches and Collaborative University Graduates as faculty. We will call on the recently distributed Coaches Collaborative Toolbox. Afternoon sessions will consist of tailored breakout sessions designed to providing coaching and spread ideas to specific roles i.e. sponsors, champions and change agents. The workshop will be designed to provide mentoring and Learning Activities for Station Performance Measure Champions. Each Station will complete an action plan for the local spread of Advanced Clinical Access principles.

- An integral part of our Strategic plan is to develop Missed Opportunities analytic tools and Spread Measurement Screening Assessment. It is expected that these tools will help identified areas where VISN and Station Advanced Clinical Access groups can best structure activities and change.
- We plan to establish how best we can use local Advanced Clinical Access Committee or equivalent and Champions. Initially simply identifying the appropriate structure and leadership of this group. Stations have identified clinical champions for Performance Measure clinics at each station. This group should serve in a lead role with local Station ACA Steering committees or their equivalent. Our plan is to maximize their coaching abilities and use. A most important part of our plan addresses “What is the work of the local Steering Committee?”

Implementing regularly Scheduled Advanced Clinic Access Consultative Site Visits will enable us to promote ACA spread. Each station will have twice yearly visits designed to be a two day consultation by ACA Subject Matter Experts. Visits will involve learning activities and spread of best practice. We essentially will be taking ACA on the Road. Each Visit and Team will be tailored to the Stations’ needs as identified by our available assessment tools and ACA Scorecard. Pre-work and visit structure will be developed in concert with Station leadership. VISN staff will provide mentoring and coaching. This may entail some travel but every effort will be made to use geographically clustered staff. Pictel can be an essential part of learning activities.

A report will be generated to Network and Station leadership focusing on opportunities found to spread ACA. An assessment of the Certification Process and scheduling accuracy will be included.

VISN 1 plans three collaborative for 2006. They are: ACA Administrative Collaborative; C4 Colorectal Cancer Care Shadow Collaborative; Sensory and Rehabilitation Services Collaborative is planned for the fall.

A series of Administrative /Data Calls will be scheduled for each month. Topics would include the Certification Process, Scheduling Accuracy, Access dashboards, Consult Management, Electronic Wait List (EWL), Pro Clarity, No Show Analysis, and Flow Charting. It is expected the calls will serve to provide coaching and spread of available ACA tools.

VISN 1 plans to continue to draw on the extremely productive VISN 1 Advanced Clinical Access Steering Committee. The structure and makeup of this committee will be reviewed to ensure there is appropriate representation of all service lines and ACA Champions.

Specialty and Acute Care Service Line:

Implementation of the principles of Advanced Clinic Access within the Specialty and Acute Service Line (SAC) is considered to be a critical component of achieving wait times within VHA Standards. SAC Local Service Line Managers and their support staff are expected to have knowledge of the 10 key changes that are the central to successful implementation of ACA.

The VISN plan of action to ensure ACA is deployed within all specialties is as follows:

- Appoint VISN champions for each of the performance clinics.
- Appoint local ACA change agents for each of the performance clinics at all facilities.
- Request that each Local SAC Manager identify goals for ACA implementation for FY 2005 and 2006.
- Enlist the assistance of VISN ACA staff to provide educational sessions on ACA principles as needed at each Medical Center. The need is to be determined by the SAC Manager in collaboration with VISN ACA Staff.
- Each Local SAC Manager is to provide the SAC Network Service Line Director (NSLD) with a monthly update on progress in ACA implementation including data demonstrating if change has been achieved.
- Mandate that all requests for resources from the SAC Service Line Managers include confirmation that ACA principles have been or are in the process of being implemented in the specialty requesting resources.

2. Evolve a seamless transition process

- Use of the 1010-EZ electronically and via the paper form is in place for enrollment.
- Demobilization meetings will continue across the VISN to assure timely enrollment and customer service for this new group of veterans.
- Expand/enhance medical and mental health services
- Incorporate Vet Centers in our OIF/OEF processes and outreach activities
- Develop VISN 1 OIF/OEF brochure to be used by all medical centers for demobilization session

3. Evaluate demand and determine priorities for CARES consistent with resources (See Part B.)

Strategy 3 Continuously improve veteran and family satisfaction with VA care by promoting patient centered care

- Develop methods for advancing patient self management competency that enable patients to share in decision making and improve health outcomes
- Fully deploy MyHealthVet as each new additional capability released
- Implement new patient orientation programs across the network.
- Develop patient “take home reports” for common chronic disease conditions

Strategy 4 – Promote diversity, and satisfaction in the workplace, in a culture that encourages innovation

1. Promote a system-wide comprehensive program for recruiting personnel in scarce professions and career fields.

- Recommendation 1 - All new postings for any nursing positions should go through the Nurse Executive to ensure all nursing standards and criteria are met. Recommendation 1 was unanimously approved and should be included in the draft VISN 1 Professional Accountability for Nursing Staff Policy.
- Recommendation 2 - Members of the VISN 1 Nurse Executive Committee and the Clinical Service Line Directors will meet on a bi-annual basis.
- Recommendation 3 - Bi-annual meetings of the VISN 1 Nurse Executives and the VISN 1 Clinical Service Line Directors was unanimously approved.

The VISN Human Resources (HR) Committee is working with the Education Center to promote a greater awareness of the multitude of HR flexibilities available and to ensure VISN and local management/supervisory training programs include appropriate recruitment flexibility topics for maximum utilization of available recruitment tools and resources to enhance recruitment for scarce professions and career fields.

2. Improve VA's ability to recruit trainees into the permanent workforce following training.

Provide exposure to a variety of programs and learning opportunities that enhance the intern's experience and interest in VA. In addition, offer them challenging assignments with appropriate training and support to demonstrate the contributions they can make. Whenever feasible, allow students to rotate to other VISN 1 facilities for an expanded experience. Prior to expiration of the training assignment, supervisors should consult with their local Human Resources Office to determine the available hiring authorities.

3. Implement recommendations of the Nursing Commission

The VISN I Nurse Executive Leadership Council met with the Clinical Care Line Managers in February 2005 to discuss the National Commission on VA Nursing recommendations. Those recommendations from the Commission report that could be implemented at the VISN level had action plans/strategies identified.

- Develop a draft VISN policy to address Professional Accountability for Nursing Staff, similar to the local policies in place at White River Junction and Boston that will address all of these issues. Once a draft is developed, it should be sent for review and comment to the Clinical Service Line Directors and the Human Resource Committee. Comments from both parties will be sent back to the Chair, Nursing Executive Committee for final review and incorporated into a final VISN policy. Recommendation 2 was unanimously approved. The Nursing Executive Committee will develop a draft policy for review by the Clinical Service Line Directors and the Human Resource Committee.
- All policies related to nursing or nursing standards should go through the appropriate nursing staff for review. This will be included in the draft policy in recommendation 1.
- Human Resources will develop a VISN 1 Matrix clearly defining direct supervisors.
- Letters will be sent to each member of the VISN 1 Nursing Staff detailing direct line authority and supervisions.
- Nursing group should develop a VISN policy on work related and non-work related injuries establishing guidelines for granting light duty and reasonable accommodation requests.

Strategy 5 – Promote excellence in business practices through administrative, financial and clinical efficiencies.

1. Apply ACA Principles to business functions

The Business Setting:

At this time, the ACA efforts are directed toward two primary areas for the upcoming collaborative: Medical Care Collection Fund (MCCF) Coding and Office of Workers' Compensation Programs (OWCP). The Coding collaborative will assist with identifying opportunities to enhance efficiency and reduce or eliminate rework activities of the coder, ultimately allowing MCCF to bill appropriately and timely. The OWCP collaborative focus is on reducing costs through assessment of our existing processes and opportunities for improvement. Both of these will promote excellence in business practices through administrative efficiencies.

Expand in-house capacity and reduce fee and contract care is not an area that the ACA Collaborative is going to be addressing for the next 9-month period. VISN 1 begins

educating appropriate areas on applying ACA principles to their work practices. The Business Office Managers have been invited to participate in the Collaborative and our first Learning Session is scheduled for July 2005.

2. Perform efficiency review of VHA supply chains. All facility inventories will be reviewed to maximize compliance to standardization of supplies through the fullest utilization of the contracting hierarchy. The primary source for orders will be against national Blanket Purchase Agreements (BPAs) that have established best pricing. All supplies not covered by these BPAs will be considered for consolidate procurement from FSS contracts, and for items not on contract, VISN contracts will be pursued to obtain savings.

Equipment requirements over \$100K and VISN wide needs for similar products that exceed \$100K are processed through the VISN Equipment Committee to achieve better pricing, uniformity of maintenance and standardization of patient care. All other facility equipment needs will be reviewed at the VISN level prior to procurement to pursue standardization and consolidated pricing.

- Upcoming service and maintenance contracts for all facilities will be reviewed for commonality of requirements to obtain reduced pricing and mutual support among the VISN Clinical Engineering staff to maximize skilled technical support.
- Pharmacy Service receives the maximum discount on supplies by the utilization of the mandated Prime Vendor for all pharmaceuticals. Guidance to the Pharmacy Service will be implemented to require supply requirements not available through the Prime Vendor to be consolidated on the VISN level to establish contracts that will ensure standardization and availability.
- The Business Office will gather details on all fee basis services processed at all the facilities. Standard contracting formats will be utilized to ensure compliance with clinical needs and all services not currently under contract will be considered for standardization of statements of work and potential consolidation if possible. Logistics will work closely with the Business Office to maximize the implementation.
- Prosthetics Service will implement new policies to establish eligibility conditions for eye glasses, hearing aids, surgical implants and home oxygen. This will establish a standard of care across the VISN and ensure uniform criteria are used at each facility to issue medical devices and supplies.

3. Improve and standardize revenue cycle activities

- Patient Financial Services System (PFSS) – this is temporality on hold from CBO/VACO;
- Consolidated Patient Account Centers (CPACs) – this is temporarily on hold from CBO/VACO and is being overseen by VACO
- Standardize encounter forms for specialty clinics to assure workload capture;

- Develop standardize reports to be run from QuadraMed for sharing with service lines to insure compliance and business integrity;
- Expand the coding pool concept by developing a centralized coding center at VISN 1 medical center;
- Expand the functions of the consolidated call center to include first party follow-up;
- Begin consolidating MCCF related activities of Bedford and Manchester VAMC under one leadership.

Strategy 6. Focus research and development on clinical and system improvements.

1. Identify and assess opportunities for extensive VA involvement in the research and practice of Genomic Medicine.

VA Bedford's systems biochemistry group is directed at finding biochemical risk factors, predictive, and therapy directing markers in disease. The systems biochemistry group's principle capabilities are in Metabolomics and Metabolomic/Genomic interactions with a major focus in CNS disorders.

VA Bedford has programs in neurodegenerative diseases such as Amyotrophic Lateral Sclerosis (ALS), Parkinson's, Huntington's and Alzheimer's Disease, and in affective disorders such as Schizophrenia. The higher incidence of ALS and affective disorders in the veteran population is of particular interest to the systems biochemistry group.

The systems biochemistry group will integrate MS capabilities with the preliminary ECA/MS systems, developed under the Roadmap Grant and put these systems into routine use. This will provide Network 1 with a unique capability in the area of Metabolomics that would not have been available for two more years.

Also, VA Bedford is developing a sample archive suitable for both Genomic and Metabolomic studies based on our interactions with and position in the joint NIH/NIST working group on standards for Metabolomics.

VA Bedford is particularly interested in pursuing interacting with groups that plan to archive biological samples from returning Veterans for the purpose of discovering risk factors or predictive factors of disease.

The Providence VAMC has an Addiction Research Program which is exploring behavioral, proteomic and genetic risk factors for alcohol and nicotine dependence. The goal of the program is to identify these risk factors and provide appropriate interventions and treatments.

2. Increase collaboration between Research and Operations to use Health Services Research and the QUERI model to improve care delivery.

The Targeted Research Enhancement Program (TREP) at the Providence VAMC has several research projects in primary care that look at the treatment of long term disease and disability in the VA clinical programs. It is the goal of this program to enhance treatment in the clinics and provide a faster implementation of new clinical guidelines. The group is particularly interested in new clinical treatments for newly returning vets especially those with amputations and other major health issues.

The Chief Medical Officer (CMO) is heavily involved in the multi-VISN Athena Group to improve hypertension through health systems innovations. VISN 1 will actively participate in patient safety initiatives and research. The CMO is a member of the Diabetic Query Group. He is active in supporting research and applying research to improve patient quality in diabetic and amputation care and prevention.

Strategy 7 – Promote excellence in the education of future health care professionals and enhance VHA partnerships with affiliates.

Reaffirm and update Policy Memorandum #2 to assure equitable harmonious and synergistic academic affiliations.

VISN 1 will strive to initiate and promote student, residency, and fellowship training programs with our academic affiliates that put VA ahead of other systems in the areas of emerging interest to VA and the nation. Examples of such areas are medical informatics, geropsychiatry, genomics and the clinical applications of genomic research, clinical informatics for nursing and allied health professionals, and care coordination/telehealth.

VISN 1 holds bi-monthly Academic Advisory Board meetings with the deans of the academic affiliates, and VISN 1's academic affiliation officers to share the results of the Learners' Perception Surveys, and make recommendations for improving education experience for the trainees.

VISN 1 will collaborate with affiliates and the office of care coordination to develop a special fellowship in information technologies. And develop curricula for residents to become competent in telemedicine. VISN 1 will seek ways to expand academic affiliation agreements with local institutions that include historically under utilized technical schools, colleges, and universities.

VISN 1 will appoint a Point of Contact (POC) who will serve as Special Emphasis Program Manager for developing plans and strategies that would be used to form affiliation agreements with minority institutions throughout New England.

VISN 1 CMO will brief the Clinical Leadership Committee (CLC) on the results of the Learners' Perception Surveys at annual CLC meetings, and make recommendations to ensure synergy with the trainees, affiliates, and VA is maintained to improve learner satisfaction. The VISN 1 CMO has suggested that an innovative method of enhancing a strong, enduring linkage between VA and its academic partners would be the development of a Veterans' Studies Program as a formal offering in the universities' academic

curriculum. VISN 1 will continue to use the Learners' Perception Surveys to improve the learning environment of learning for the trainees.

Strategy 8 - Promote health within the VA, local communities and the nation consistent with the VA's mission.

1. Partner with local communities, industry organizations and other Federal agencies to promote health, including:

- Obesity and diabetes prevention and treatment programs
- Health lifestyle choices

VISN 1 Actions:

- Participate in state-wide diabetes care collaboratives.
- Collaborate with state, industry, National Guard and other local community agencies in implementing elements of MOVE program.

2. Increase public, employee, and volunteer awareness of VA's achievements and contributions to the community and Nation.

VISN 1 Actions:

- The VISN Communications Officer chairs the VHA Communications Advisory Board (CAB) and is a member of the NLB Communications Committee. As such, the Communications Officer participates in these communications structures to ensure a coordinated communications plan for increasing awareness of VA achievements.
- A VISN 1 Communications Council was established in FY2000 to facilitate effective communications across the Network medical centers and CBOCs, and with internal and external stakeholders. Council membership consists of the Public Affairs Officers at each medical center, Network staff, and veteran representative. The Council provides a structure for increasing awareness of VA achievements and contributions.
- The Network will continue to utilize Network and facility publications, the website and other stakeholder forums such as the Management Assistance Council (MAC) and local Mini-MACS to publicize VA's achievements and contributions.

3. Strengthen VHA emergency preparedness training and response including collaborations with communities and other organizations.

VISN 1 Actions:

- Survey medical centers to identify collaborations with communities and other organizations
- Standardize decontamination processes across the network
- Standardize respiratory protection fit testing
- Provide respiratory protection training across the network
- Incident command training for Executive Staff

Part A: Mental Health Narrative (See also Appendix A Templates)

The VISN 1 Mental Health Service Line (MHSL) has developed the following initiatives to address all program areas.

Telemedicine

The Comprehensive VHA Mental Health Strategic Plan and recommendation 3.2.39 (initiatives 1-5) of the Action Agenda (AA), require that VHA ensure that “veterans living in rural areas have access to quality mental health care”. VISN 1 has focused on developing our Telemental Health Programs to meet this expectation. In addition, recommendation 6.1.73 A, B and C (initiatives 1-5) require that VHA Mental Health “expand mental health telehealth care to all facilities, CBOCs and Vet Centers”.

Telemental Health Services in VISN 1 have focused thus far on linking key CBOCs that are geographically distant from their parent facilities to the parent facility via videoconferencing technology. We are nearing the completion of three pilot programs (Togus to Caribou; WRJ to Bennington and Providence to Hyannis) now and are well positioned to expand these initiatives. With the support of the CIO line, a 3-year plan to ensure state of the art videoconferencing systems in all VISN 1 CBOCs is currently underway. The VA Connecticut Healthcare System recently began to provide some limited MH services between one of its main campuses (West Haven) and Winsted CBOC. In FY06, we expect expansion of these initiatives to include New London CBOC, Waterbury CBOC and Stamford CBOC in Connecticut and the Rumford CBOC in Maine.

Future initiatives may include specialized consultation services across VAMCs within VISN 1 as well as the potential to provide expert consultation to other VISNs. It is expected that in FY06, approximately \$9M in enhancement funding from VACO will support additional initiatives in Telemental Health.

Care Coordination and Home Telehealth (CCHT)

Initiatives related to CCHT for MH are related to recommendation 6.1.72 (initiatives 1-5) which requires VHA Mental Health to “improve access through use of technology and selected infrastructure improvements”. This is also a means to achieve improved clinical efficiencies with our scarce case management resources in Mental Health. Currently, a pilot project is underway at Northampton where videophones have been placed in Residential Care Homes in the community to better understand how these devices may reduce travel and increase efficiencies for our social work staff who provide case management to those veterans who reside in the community at a Residential Care Home facility.

VISN 1 is currently working to identify mental health care coordination opportunities using in-home messaging devices and other emerging technologies. In FY06, we will identify specific staff at each facility who will obtain training as “Care Coordinators” through the VHA Office of Care Coordination’s Training Center. We also plan to ask each site to

identify a specific patient population to target for home telehealth interventions and assign workload targets to each site. We will follow the workload capture and coding guidelines to ensure that this work is properly credited to the appropriate MH department by DSS. Significant staff training issues have been identified and a training plan is under development to assist staff in meeting these expectations. We plan to continue to work closely with the Geriatrics and Extended Care Service Line staff who have already been performing this work for veterans with significant medical problems.

Substance Abuse

Consistent with the Comprehensive VHA Mental Health Strategic Plan and recommendation 1.2.8 A, B, C and D (initiatives 1-40) of the Action Agenda (AA), VISN 1 seeks to “restore our ability to consistently deliver state of the art care for veterans with Substance Use Disorders”. In addition, the national plan specifies that Opiate Agonist Treatment in urban centers with high prevalence of heroin use and large CARES-projected gaps in VA methadone treatment be addressed.

Our Providence, RI facility was awarded an enhancement grant from VACO recently, which will expand our capacity to meet the needs of veterans seeking Opiate Substitution Therapy (OST) and will also offer intervention with Buprenorphine. This will now establish 3 locations within VISN 1 where our veterans can access OST services (Boston, Connecticut and Providence). VACO has further supported the needs of VISN 1 by funding additional Substance Abuse treatment professionals at our Togus, ME facility to restore their ability to meet the needs of veterans with Substance Use Disorders. Specifically, we plan to open a Buprenorphine clinic in Portland ME (the largest urban area in Maine) in FY06.

According to Stage 2 Strategic Planning Guidance 2006-2010, there is a need to expand Other: Inpatient Mental Health Programs in the North and Far North Markets. Based upon the recent CARES projections for VISN 1, we are planning to expand the availability for residential substance abuse treatment in our North and Far North markets.

The projection demand data indicated that there was a gap of 16,147 BDOC in the category, Other: Mental Health Inpatient Programs in the Far North Market. The proposal stated that Togus, a facility without any inpatient Substance Abuse capacity, would receive a total of 50 beds. There would be a 25-bed Substance Abuse Residential Rehab Unit at Togus and, following successful treatment, the patients could be admitted to a 25-bed CWT/TR house in Portland. Portland was selected for the site of the CWT/TR because it is the most populated area in the state where supportive-community employment opportunities exist in greater numbers than in Augusta and, the majority of patients treated for substance use disorders reside in southern Maine. Providing local residents with a program serving as a transition between treatment and integration into the community will promote successful outcomes.. A 15-bed SARRTP is also proposed for WRJ, to be constructed by 2011. In addition, there is a need to locate a 15-bed SA CWT/TR program at the Manchester facility in the future.

The VISN 1 Substance Use Disorders Workgroup (comprised of local SA program leaders) continues to meet monthly by conference call to review changes in workload to ensure that each facility has capacity to address the demand for new services. These monthly contacts help us to better understand how we can work together to provide a full continuum of substance use disorder services for veterans in VISN 1.

Homeless

Consistent with the Comprehensive VHA Mental Health Strategic Plan and recommendation 2.3.21 (initiatives 1-6) of the Action Agenda (AA), VISN 1 seeks to establish additional housing resources for the homeless veteran. A preliminary award of two grants for transitional housing in Maine from the VA Grant & Per Diem program will greatly enhance the number of community transitional housing units in Maine. In addition, based on the CARES demographic projections, the MHSL recommends that VISN 1 construct a new domiciliary program by FY10 to meet the housing needs of veterans in the Far North market and support the ongoing rehabilitation efforts of these veterans. This site is targeted to “reduce geographic variation and enhance access for homeless veterans” as stated in recommendation 1.2.8 A, B, C and D (initiatives 1-40). This will also “provide further emphasis on recovery and rehabilitation in mental health care” (recommendation 5.1.50 A, B and C (initiatives 1-5). In addition, The Errera Community Care Center at VA Connecticut will be partnering with the State of Connecticut to create additional community based housing units for veterans eligible to use Section 8 housing vouchers from HUD.

VISN 1 Homeless Outreach programs have strong existing ties to our MH and SUD treatment programs (recommendation 1.2.8 A, B, C and D (initiatives 1-40). In addition, VISN 1 MH Homeless Outreach programs have already established a close collaborative relationship with the Primary Care Service Line to “integrate primary medical care with homeless services” as required in recommendation 1.2.7 (initiatives 1-13). Of particular note, is a program at VA Connecticut where the Homeless Outreach Nurse goes into the field and accompanies homeless individuals to their medical appointments and ensures that they are seen quickly and are adequately treated. We plan to use this as a model to enhance homeless outreach medical services at other VISN 1 facilities.

Establishing case management programs for homeless veterans with mental illness has been an identified goal of the VISN 1 MHSL since it was presented to the Strategic Planning Committee on November 18, 2004. We were fortunate to have special needs grant projects awarded to VISN 1 to implement programs for homeless chronically mentally ill veterans, coupled with critical time intervention (CTI) services. Boston Healthcare System (BHCS) and Bedford were awarded one project and Connecticut Healthcare System (CHCS) and Northampton received a second project. Deployment of the resources provided is a key goal for the next fiscal year.

Our local homeless coordinators currently work closely with facility OIF/OEF liaisons to ensure outreach occurs (recommendation 1.2.7, initiatives 1-13). Recently awarded VA Central Office grants to enhance treatment options for OIF/OEF servicepersons with

Posttraumatic Stress Disorder (PTSD) and other mental health needs will support this effort.

A special initiative has designated outreach to incarcerated veterans as a priority. The goal is to provide transition assistance to released veteran prisoners and facilitate their smooth transition back to their community

CBOCs

The VISN 1 Mental Health Service Line is committed to “ensuring a full continuum of compassionate care to veterans with mental illness” (recommendation 1.2.8 A, B, C, and D). Our goal for 2006-7 is to ensure that 85% of CBOCs with over 1500 unique veterans provide at least 15% of visits in mental health. Our strategy to reach this goal is threefold:

- We are currently developing contracting relationships with Mental Health clinics that are geographically proximate to our CBOCs. In best cases, the contractor would be located in the same medical office building as the CBOC. In Connecticut we have identified and completed contracting with one such clinic in Waterbury and are working on a second contract for Winsted. A third contract for Stamford should be complete by the end of the summer. In Maine we are seeking a similar provider for the Rumford CBOC but as yet have not identified an appropriate vendor. In the interim, staff from Togus have begun seeing mental health patients in the clinic and a telemental health program is about to begin linking Rumford with Togus.
- Support the purchase of high quality telehealth video equipment for all CBOCs (an overall VISN IT goal) and train appropriate staff at the clinic and parent facility in its use. Our plan is to partner staff trained this year with new staff about to forge a mentoring relationship.
- Over time we plan to re-deploy facility based staff to CBOCs so as to provide care to veterans in closer proximity to their homes. This has already been successfully accomplished at Bedford and we will use that as a model for other facilities in FY06 and FY07.

Seriously Mentally III

A Memorandum has been sent by the VISN Director to each State Director of Mental Health Services (recommendation 2.4.23) that identifies the VHA liaison who is available to provide information about VHA services and eligibility. These VHA MH liaisons will clarify procedures to refer eligible SMI veterans to VHA for sustained treatment when required. In FY06, brochures will be developed for distribution throughout each New England State and a series of meetings will occur to integrate VA Services into each State's Mental Health Service Plan.

In FY06-7 we plan to implement Supported Community Employment (recommendation 2.3.22) to assist SMI veterans in obtaining meaningful employment in real jobs in their local community. VA Connecticut is to provide leadership as the funded “mentor site” to staff regarding the types of interventions and techniques necessary to accomplish this task. We plan to deploy the 7 VISN positions that were recently awarded and have at least 35 veterans actively participating in this program by 2007.

Peer-to-Peer Support (recommendation 2.2.16) and similar programs have been implemented at the VA Boston Healthcare System, Providence VAMC and VA Connecticut Healthcare System. Our goal for FY06 is to employ 7 veterans as peer counselors using funds awarded to VA Connecticut from the recent Request for Proposal (RFP) process (recommendation 2.2.18). We anticipate that this pilot program will lead to further use of this treatment modality in the future.

Outreach to Families (recommendation 2.2.11 3) Consumer Advisory Council (recommendation 2.2.14): VISN 1 instituted a Network MH Veterans and Family Advisory Council in 2001 to ensure that the input and feedback from veterans and their family members are well considered in the planning process. All but two stations (Manchester and Togus) have implemented similar local councils to assist MH leadership in planning. Manchester is now implementing a Veteran and Family and Advisory Council. By the end of FY06, we expect that Togus will identify appropriate members of such a council. We also expect by the end of FY06, that each facility will have contacted their local National Alliance for the Mentally Ill (NAMI) representative and invite them to attend a local council meeting or to be an active member of their council.

Evidence Based Recovery Model (recommendation 2.2.13, initiatives 1-3): VISN 1 has been a leader in educational programming with regard to the evidence based recovery model. Our goal for FY06 is to sponsor at least one educational conference as a follow-up to the two that were sponsored this past year.

Expanding Services:

According to Stage 2 Strategic Planning Guidance 2006-2010, there is a need to expand Other: Inpatient Mental Health Programs in the North and Far North Markets. In the North Market, it is proposed that an 18-bed Long Term Psychiatric Inpatient Program be established at Manchester by FY10.

To meet the Domiciliary and PR RTP needs of VISN 1, it is proposed that two new 25-bed domiciliary units be constructed by FY10; One at Togus (which will serve the Far North and North Markets) and the other at the West Haven campus of the VA Connecticut Healthcare System which will serve the West Market.

OIF/OEF and PTSD

Seamless Transition Initiatives

As required by recommendation 1.1.5 A, B and C (initiatives 1-11) and recommendation 2.1.9 A (initiatives 1-5), VISN 1 has been aggressive in providing outreach to returning OIF/OEF military and assisting in screening returning service members for mental illness

and/or substance abuse problems. VHA staff meets with returning service members to inventory clinical needs and provide readjustment counseling when needed. They also provide an overview of services available at local VA sites and establish themselves as a point of contact. Our goal is to promote coping skills, resiliency and community support among these newest veterans (recommendation 1.1.5 A, B, and C Initiatives 1-11).

VISN 1 MHSL works to provide early interventions to OIF/OEF veterans to minimize the risk of the development of serious mental illness among returning service members. VA Connecticut, Providence, Boston and Bedford have new FTEE, funded through VACO RFAs, that will provide outreach and early intervention to returning service members.

A Memorandum of Understanding has been developed between VISN 1 and the 94th Regional Reserve Command Office to provide services to New England Reservists. We expect this agreement to be finalized in FY06. Each Reserve Unit will be provided a liaison that will be available to assist in the referral for, and scheduling of, appropriate clinical services.

New FTEE have been added to VA Connecticut and Providence to support these initiatives. At VA Connecticut, an innovative program linking the VA with the State Labor agencies has been designed to maximize the available resources to promote quick return to full employment for these veterans.

Specific Treatment Program Initiatives by Site:

The Specialized Inpatient PTSD Unit (SIPU) at Northampton is actively monitoring the needs of returning veterans to determine how best to modify the existing program to better meet the needs of this younger population.

The Boston Healthcare System will implement a PR RTP designed for Women Veterans with Substance Abuse and PTSD in FY06. This program will be located on the Brockton campus and is supported by the National PTSD Clinical Center. The program is designed to be a referral center and will accept referrals from other VISNs.

VISN 1 PTSD Workgroup (comprised of local PTSD program leaders) continues to meet by conference call to review changes in workload and to ensure that each facility has capacity to meet the demand for new services. Workload is routinely monitored to identify the need for access based upon the demand for services.

Part B: Capital Asset Realignment for Enhanced Services (CARES) Narrative

CARES data show most clinical programs in Network 1 being sustained or expanded. Facilities in Network 1 have significant infrastructure needs that need to be addressed immediately. In 2001, the VA Office of Facility Management (OFM) studied the integrity of the infrastructure systems for Network 1. The systems for over 8,000,000 square feet of building space ranged from poor to good condition. However, there were a significant number of systems that were found to be below par. The systems included site, architectural, HVAC, electrical, plumbing, structural, and elevators. The number of current

systems deteriorating will certainly increase as the buildings are continuing to be used at the growing activity level. Current funding to repair these systems is insufficient to stem this deterioration. Significant funds are needed to bring these systems up to par and local community standards.

The CARES planning cycle indicates a need for increased space to support our projected workload. If we do not receive a significant influx of infrastructure correction funds to improve the existing facilities in this VISN, continued infrastructure deterioration will lead to the inability to support the projected workload. Eventually significant construction will be required to replace the infrastructure that is beyond repair.

The complexity of realigning clinical services and campuses requires careful planning in order to ensure a seamless transition in services. All changes recommended through the CARES process have been included in the Capital Asset Plan that will be carried out over several years. This plan will be a multifaceted process, depending upon whether implementation of specific initiatives requires additional capital, recurring funding, policy changes, or realignments. No services will be realigned without alternative sites of care being available and operational. Savings or revenues realized from enhanced use leasing will be used to benefit veterans in the communities where the affected campuses are located.

The Network's strategic planning process ensures that its capital asset infrastructure is configured to meet the demand for VA health care services during the next 20 years. The CARES process is a data-driven approach to analyzing veterans' projected health care needs. The final plan included major construction projects to modernize facilities at Boston Healthcare System, Providence VAMC, Connecticut Healthcare System and Togus VAMC. Additionally, the Network identified a major need to improve the infrastructure of numerous aging buildings. As a result, a program utilizing minor construction and nonrecurring maintenance projects has been developed and included in the Network 1 Capital Asset Program.

Several areas will be focused on in this planning cycle, with special emphasis on the transformation of the mental health program and the identification of long-term care needs. The Network is currently undergoing a feasibility study regarding the relocation and resizing of the Boston area campuses. Upon completion of the study, the Network Strategic Plan will be adjusted accordingly.

Capital Planning for Mental Health

The VA New England Healthcare Five Year Plan was reviewed in the new planning data for the Mental Health workload. The workload has indicated a need for the following capital projects.

Parent Facility	Project Number	Project Title	Description	Bud get Year	Estimated Cost
				Proposed	
Manchester	VISN 1-Manchester-2008-3	Mental Health Additions and Improvements	Renovations to mental health clinics. Construct 18 Bed Long Term Psych and a 15 bed Substance Abuse CWT/TR	2008	\$6,700,000
Togus	VISN 1-Togus-2008-8	Construct 25 Bed Dom	Construct a new Dom unit at the Togus campus. project is based upon Stage 2 Strategic Planning	2008	\$2,682,328
White River Junction	VISN 1-White River Junction-2008-3	Construct 15 Bed Substance Abuse Residential Rehabilitation	Construct a 15 bed building for Substance Abuse Residential Rehab	2008	\$2,500,000
Togus	VISN 1-Togus-2009-4	Substance Abuse Residential Rehab	Construct 25 bed Substance Abuse Residential Rehab Unit	2009	\$3,500,000
West Haven	VISN 1-West Haven-2009-5	Construct 25 Bed Dom	Construct a 25 Bed Dom Unit	2009	3,343,192
Togus	VISN 1-Togus-2010-4	Construct 25 Bed Sub Abuse CWT/TR	Purchase land and construct a 25 bed substance abuse CWT/TR in Portland, ME	2010	\$4,500,000

The projects reflect a large gap in the number of residential beds within this VISN.

The Five Year Plan has been updated in the IBM database and also attached as per the guidance.

Part B: Capital Asset Realignment for Enhanced Services (CARES)

Review of the Mental Health Workload data has indicated a need for several capital projects. The projects have been added to the Five Year Plan and the templates required in the planning guidance.

The CARES initiatives identified in the “Secretary’s Decision” and in the pre-populated templates have been addressed as required in the planning guidance. The most notable changes are:

- Mental Health Capital Initiatives added. They are all Minor level projects.
- Requesting the removal of the Initiative to contract inpatient medicine care for the North and Far North market. The new workload data is showing either small increases or decreases to the required beds. The small increase can be managed on an as needed basis.
- Requesting the VBA collocation to the VA Connecticut Newington Campus be removed from the tracking list as the action has been completed. The VBA is no longer on the Newington campus.
- We delayed any significant development of the Inpatient Access Evaluation (Transition) until decisions are made in the Boston CARES Study. As the study is related to the referral patterns to the Boston Area facilities, a rigorous study can not be undertaken.

With the integration of Mental Health demand into the Strategic Planning process we are hopeful that available funds, particularly in the Major and Minor program, are expanded to support this process. We have many more capital initiatives than we expect to have available resources. Without timely and adequate support for the capital initiatives, the implementation timeframes will be beyond all current planning horizons.

Appendix A: Reporting Templates

MENTAL HEALTH

Based on the data provided by Template 1 (Mental Health) for Strategic Plan-05, there were several gaps that met defined criteria:

- Positive Gap
 - Far North Market: Other: Mental Health Inpatient Programs (SUB ABUSE RES REHAB, HCMI CWT/TR, SA CWT/TR, PTSD/CWT/TR, GENERAL CWT/TR, LONG-TERM PSYCH, STAR I,II,&III PGMS, SUB AB STAR1,11,111, EVAL/BRF TRMT PTSD)
 - North Market: Other: Mental Health Inpatient Programs
 - VISN: Dom and PR RTP
- Negative Gap
 - West Market: Ambulatory: Behavioral Health
 - East Market: Inpatient Psychiatry and Substance Abuse
 - East Market: Other: Mental Health Inpatient Programs

While other gaps were present, only those identified above reached the required threshold.

Strategies

Based on guidance provided by VACO, all issues affecting the Boston area were to be deferred, pending the resolution of the CARES project. The data supports a reduction of beds in the East Market. However, since Providence is the only facility in the East Market outside of the Boston area, and has no beds in the category, Other: Mental Health Inpatient Programs, and has only 17 psychiatry beds for veterans who live in the State of Rhode Island, it was decided that no actions would be identified for the East Market to address the identified negative gaps.

VISN 1 has historically recognized that VT, NH, and ME had fewer mental health programs than the East and West Markets. Stage 2 Strategic Planning Guidance for 2006-2010 is designed to address the imbalance of mental resources among markets in each VISN. In VISN 1, the model indicates the need to close beds in the East Market while establishing beds in the North and Far North Markets.

The projection demand data indicated that there was a gap of 16,147 BDOC in the category, Other: Mental Health Inpatient Programs in the Far North Market. The proposal stated that Togus, a facility without any inpatient Substance Abuse capacity, would receive a total of 50 beds. There would be a 25-bed Substance Abuse Residential Rehab Unit (4,654 BDOC) at Togus and, following successful treatment, the patients could be admitted to a 25-bed CWT/TR house (4,654 BDOC) in Portland. Portland was selected for

the site of the CWT/TR because it is the most populated area in the state where supportive-community employment opportunities exist in greater numbers than in Augusta and, the majority of patients treated for substance use disorders reside in southern Maine. Providing local residents with a program serving as a transition between treatment and integration into the community will promote successful outcomes.

In order to address the gap in the North Market of 14,857 BDOC in the Other: Mental Health Inpatient Programs, it is proposed that an 18-bed Long Term Psych unit (5,584 BDOC) as well as a 15-bed SA CWT/TR program (4,654 BDOC) be established at Manchester which is a relatively densely populated area where there are many supportive employment opportunities.. In addition, it is proposed that a 15-bed Substance Abuse Residential Rehab unit (4,654 BDOC) be established at White River Junction.

There was a VISN-wide gap of 247 DOM & PR RTP beds in 2013 (198 DOM and 49 PR RTP) and 181 beds (142 DOM and 39 PR RTP) in 2022. According to guidance, planning any expansion for 2013 should be limited by the demands for 2022.

Table 1 – Demand	Dom	PRRP & PR RTP	Total
1. VISN FY2022 Demand Projection	142	39	181
VISN where demand will be met			
2. Within the VISN	142	39	181
3.a. Other VISN # 2	0	0	0
3.b. Other VISN # 3	0	0	0
3.c. All other VISNs	0	0	0
4. Total line 2 and 3s (must equal total in line 1.)	142	39	181

There are 86 DOM beds currently available in VISN 1 (40 beds at Bedford; 46 beds at Brockton (Boston Healthcare System). There are of 46 PR RTP beds currently in VISN 1 (10 beds at Bedford; 24 beds at Brockton (Boston Healthcare System); 12 beds at West Haven (Connecticut Healthcare System). In summary, there are 132 DOM and PR RTP beds.

Table 2 - Current Facility Bed Availability Within the VISN	Dom	PRRP & PR RTP	Total
1.a. Bedford	40	10	50
1.b. BHCS	46	24	70
1.c. CHCS		12	12
2. Total Available Beds	86	46	132

Further analysis indicates that the distribution of projected demand for DOM and PR RTP beds by market is as follows:

TABLE 3		
DISTRIBUTION OF PROJECTED DEMAND BY MARKET		
	DOM	PRRT
EAST	62	17
FAR NORTH	21	6
NORTH	23	6
WEST	36	10
TOTAL	142	39

When comparing Table 1 (Projected Demand) with Table 3 (Distribution of Projected Demand by Market), the East Market has more DOM and PRRT beds than demanded. However, CARES is currently studying the Boston area to determine the appropriate structure and size of the East Market. VACO has provided guidance that VISN 1 Strategic Planning should not alter the current bed configuration until the CARES Study concludes its work. VISN 1 decided to address the 2022 gap (49 beds) by proposing a plan for 50 Domiciliary beds.

a. Establish a 25-bed Domiciliary at Togus.

Since there is no space available for renovation, it is proposed that a 25-bed Domiciliary be constructed at Togus to serve the homeless veterans in Maine as well as OEF/OIF veterans in need of extended rehabilitation.

b. Establish a 25-bed Domiciliary at West Haven.

To service homeless veterans and returning OEF/OIF veterans in need for extended rehabilitation in the West Market, it is proposed that a 25-bed Domiciliary be established by renovating Ward 1-7E.

To address the negative gap of 44,197 Stops in Ambulatory: Behavioral Health in the West Market, it is planned that there will be detrimental decreases based on demographics distributed to Newington, West Haven, and Northampton to account for the required reduction in stops by 2013.

REPORT TEMPLATE 1 (REV June 27, 2005)

Mental Health Gap Solutions by Facility for VISN 1_____

NOTES: Current and forecast workload is either inpatient Bed Days of Care (BDOC) or outpatient clinic stops.
Use as many pages as necessary.

[illegible]

VISN 1 Stage 2 Strategic Plan FY2006 – 2010

REPORT TEMPLATE 2

Mental Health Actions for VISN 1

nn

A	B	C	D	E	F
Market	Mental Health Program	Target to be achieved by end of FY 2013	VISN Actions to Achieve Target	Mental Health Strategies (from MHSP) linked to each Action	Initiatives (from MHSP) linked to each action
Far North	Ambulatory: Behavioral Health	25,286			
Far North	Inpatient Psychiatry and Substance Abuse	3,094			
Far North	OP Mental Health Program: Community MH Residential Care	624			
Far North	OP Mental Health Program: Day Treatment	1,179			
Far North	OP Mental Health Program: Homeless	3,173			
Far North	OP Mental Health Program: Mental Health Intensive Case Management	1,683			
Far North	OP Mental Health Program: Methadone Treatment	9,094			
Far North	OP Mental Health Program: Work Therapy	16,998			
Far North	Other: VA Mental Health Inpatient Programs	16,147	Establish at Togus a 25-bed Sub Abuse Res Rehab Program and at Portland a 25-bed SA CWT/TR	2,3,8	4, 14
North	Ambulatory: Behavioral Health	25,824			
North	Inpatient Psychiatry and Substance Abuse	229			
North	OP Mental Health Program: Community MH Residential Care	1,127			
North	OP Mental Health Program: Day Treatment	4,597			
North	OP Mental Health Program: Homeless	3,201			
North	OP Mental Health Program: Mental Health Intensive Case Management	3,240			
North	OP Mental Health Program: Methadone Treatment	9,339			
North	OP Mental Health Program: Work Therapy	17,048			
North	Other: VA Mental Health Inpatient Programs	14,857	Establish at Manchester a 18-bed Long-Term Psych Program and a 15-bed SA CWT/TR and at WRJ a 15 Bed Sub Abuse Res Rehab	2,3,8	4, 14
East	Ambulatory: Behavioral Health	-8,762			
East	Inpatient Psychiatry and Substance Abuse	-7,125			
East	OP Mental Health Program: Community MH Residential Care	-4,291			
East	OP Mental Health Program: Day Treatment	-3,821			
East	OP Mental Health Program: Homeless	-1,398			
East	OP Mental Health Program: Mental Health Intensive Case Management	-6,236			
East	OP Mental Health Program: Methadone Treatment	-2,488			
East	OP Mental Health Program: Work Therapy	-26,040			
East	Other: VA Mental Health Inpatient Programs	-21,044			
West	Ambulatory: Behavioral Health	-44,197	There will be incremental decline in workload based on demographics at West Haven, Newington, and Northampton	5	15
West	Inpatient Psychiatry and Substance Abuse	-2,653			
West	OP Mental Health Program: Community MH Residential Care	1,919			
West	OP Mental Health Program: Day Treatment	3,751			
West	OP Mental Health Program: Homeless	2,706			
West	OP Mental Health Program: Mental Health Intensive Case Management	1,713			
West	OP Mental Health Program: Methadone Treatment	196			
West	OP Mental Health Program: Work Therapy	6,084			
West	Other: VA Mental Health Inpatient Programs	-1,611			

VISN 1 Stage 2 Strategic Plan FY2006 – 2010

REPORT TEMPLATE 3 (REV June 27, 2005)

Domiciliary Residential Rehabilitation Treatment Programs Gap Solutions by Facility for VISN 1

Use as many pages as necessary.

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
VISN	Domiciliary Residential Rehabilitation Treatment Program	FY 2003 Actual Workload (Beds)	Planned increase in workload FY 2006 (Beds)	Facility or Contract	Amt of Workload @ Facility or contracted (Beds)	Planned increase in workload FY 2007 (Beds)	Facility or Contract	Amt of Workload @ Facility or contracted (Beds)	Planned increase in workload FY 2008 (Beds)	Facility or Contract	Amt of Workload @ Facility or contracted (Beds)	Planned increase in workload FY 2009 (Beds)	Facility or Contract	Amt of Workload @ Facility or contracted (Beds)	Planned increase in workload FY 2010 (Beds)	Facility or Contract	Amt of Workload @ Facility or contracted (Beds)	Cumulative increase in workload by end of FY 2010 (Beds)	Gap in FY 2012	Percentage of 2013 Gap Closed by end of FY 2010	Gap in FY 2022
1	Domiciliary Residential	132													50	Facility	50	50	247	20%	181

Template 4

VISN # 1		VISN Name:									
Capital Planning for Mental Health											
										% Difference	
Facility	Workload						Current Square Feet	Projected Square Feet		Between Current and Projected	
	2003		2013		2023			2013	2023	2013	2023
	Beds	Stops	Beds	Stops	Beds	Stops					
Togus (Mental Health: DOM)	0		25		25		0	19437	19437	100%	100%
Togus (Mental Health: SARRT)	0		25		25		0	25208	25208	100%	100%
Togus (Mental Health: SA/CW)	0		25		25		0	25208	25208	100%	100%
WRJ (Mental Health: SARRT)	0		15		15		0	15125	15125	100%	100%
Manchester (Mental Health: S)	0		15		15		0	15125	15125	100%	100%
Manchester (Mental Health: P)	0		18		18		0	33274	33274	100%	100%
West Haven (Dom)	0		25		25		0	19437	19437	100%	100%
Source: VISN 1 Space Calculators											

VISN 1 Stage 2 Strategic Plan FY2006 – 2010

Report Template 5
VISN # 1 VISN Name: VA New England Healthcare System
CARES Community Based Clinics

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V
Source: 1. LTC Demand Policy 2. MH Strategic Plan 3. Secretary's Doc 4. New/updated gaps	Link to VHA Strategy 1-8	Justification for adding or requesting removal of an Initiative (See Guidelines in the README tab)	Strategic Initiative Tracking Number	Facility Name (For tracking purposes)	V	S	Market	Parent Facility	Reason for Priority Status	Financial Linkage			Non-recurring costs, indicate Construction, Lease, Contracting or EU Tracking Number	Planned Milestones Dates (FY 06, 07, 08, 09, 10 or "beyond")							
										Workload Units	\$ per workload unit	Estimated Annual Recurring Costs		Year Planned to Open	Revised Year Planned to Open	Priority within each FY (1,2,3,etc)	Date plan submitted to VHA	Date VHA approved & submitted to VA	Date Submitted to Congress	Date Congress approved	Activation Date
3	3,4,5		CBC-V01-001	Bangor Outreach-Dover Fox	1	ME	Far North	Togus	Rural Access	768	704	\$ 148,688	392,330	2004	On hold pending Budget outcomes FY 2006 and 2007						2006
3	3,4,5		CBC-V01-002	Bangor Outreach-Lincoln	1	ME	Far North	Togus	Rural Access	1,168	704	\$ 325,224	485,120	2004	On hold pending Budget outcomes FY 2006 and 2007						2006
3	4,5,6		CBC-V01-003	Cumberland County	1	ME	Far North	Togus	Rural Access	4300	691	\$ 1,486,652	1,124,985	2005	On hold pending Budget outcomes FY 2006 and 2007						2007
3	3,4,5		CBC-V01-004	Houlton - PT-Contract	1	ME	Far North	Togus	Rural Access	300	1705	\$ 119,052	392,330	2004	On hold pending Budget outcomes FY 2006 and 2007						2006
3	3,4,5		CBC-V01-005	Rumford Outreach - Farmington	1	ME	Far North	Togus	Rural Access	300	1705	\$ 119,052	392,330	2004	On hold pending Budget outcomes FY 2006 and 2007						2007
3	3,4,5		CBC-V01-006	Rumford Outreach - South Paris	1	ME	Far North	Togus	Rural Access	300	1705	\$ 119,052	392,330	2004	On hold pending Budget outcomes FY 2006 and 2007						2007

VISN 1 Stage 2 Strategic Plan FY2006 – 2010

Report Template 6									
VISN # 1			VISN Name: VA New England Healthcare System						
CARES Construction Projects									
A	B	C	D	E	F	G	H	I	J
Source: 1. LTC Demand Policy 2. MH Strategic Plan 3. Secretary's Doc 4. New/updated gaps	Link to VHA Strategy 1-8	Justification for adding or requesting removal of an Initiative (See Guidelines in the README tab)	Strategic Initiative Tracking Number	VISN	Facility	Description	CARES Category(s)	Program (Major, Minor)	Project Number (Even if already complete)
3		This is the initial phase and when completed a series of Minors not yet identified will continue the inpatient renovation. The bed sizing will be addressed in next iteration. This project initially addresses specialty care outpatient workload. Cost estimate will be revised accordingly	CON-V01-001	1	Providence	In House IP Expansion	Inpatient	Major and Minors to follow	650-075
3		the project is being revised for reduced bed numbers VACO Planning has approved 95 beds. The cost estimate is bing revised accordingly.	CON-V01-002	1	West Haven	In House IP Expansion	Inpatient		689-133
2	2, 3, 8	Incresed workload	CON-V01-003	1	Togus	Construct 25-bed Domiciliary	Inpatient	Minor	VISN 1-Togus-2008-8
2	2, 3, 8	Incresed workload	CON-V01-004	1	Togus	Construct 25-bed Sub Abuse Res Rehab	Inpatient	Minor	VISN 1-Togus-2009-4
2	2, 3, 8	Incresed workload	CON-V01-005	1	Togus	Construct 25-bed SA CWT/TR	Inpatient	Minor	VISN 1-Togus-2010-4
2	2, 3, 8	Incresed workload	CON-V01-006	1	Manchester	Construct 18-bed Long Term Psych and Construct 15-bed SA CWT/TR	Inpatient	Minor	VISN 1-Manchester-2008-3
2	2, 3, 8	Incresed workload	CON-V01-007	1	WRJ	Construct 15-bed Sub Abuse Res Rehab	Inpatient	Minor	VISN 1-White River Junction-2008-3
2	2, 3, 8	Incresed workload	CON-V01-008	1	West Haven	Construct 25-bed Domiciliary	Inpatient	Minor	VISN 1-West Haven-2009-5

Template 7 is omitted as N/A

VISN 1 Stage 2 Strategic Plan FY2006 – 2010

Report Template 8																
VISN # 1 VISN Name: VA New England Healthcare System																
CARES Contracting Activities																
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
								Financial Linkage			Planned Milestones Dates (FY 06, 07, 08, 09, 10 or "beyond")					
Source: 1. LTC Demand Policy 2. MH Strategic Plan 3. Secretary's Doc 4. New/updated gaps	Link to VHA Strategy 1-8	Justification for adding or requesting removal of an Initiative (See Guidelines in the README tab)	Strategic Initiative Tracking Number	VISN	Facility	Description	CARES Category(s)	Workload Units	\$ per workload unit	Estimated Annual Recurring Costs	Transition Plan Complete	Feasibility Study Complete	Application Submitted	Estimated Start Year	Priority within each FY (1,2,3, etc)	Date Implemented
3		Requesting the removal of this initiative as per the new workload numbers below the total number of inpatient beds for these markets are remaining wither stable or reducing. The increase in beds for Togus can be managed if the numbers prove true.	Contr-V01-001	1	North/Far North	Contract Care for IP medicine/Access					Beyond	Beyond	Beyond	Beyond	Beyond	Beyond

Templates 9, 10 and 11 are not applicable to VISN 1 so are not included

[illegible]

VISN 1 - Minor Capital Projects Report								
VISN # 1			VISN Name: VA New England Healthcare System					
VHA Strategy #	Strategic Initiative #	Parent Facility	Project Category	Project Number	Project Title	Description	Budget Year Proposed	Estimated Cost
2,4,5,6,13	-	Bedford	All Other	VISN 1-Bedford-2007-4	Renovate Inpatient Psychiatry	Renovate two inpatient psychiatry wards to address poor condition codes.	2007	\$3,326,000
4,5,6,8,13	-	Bedford	All Other	VISN 1-Bedford-2007-7	Expand Lab and Radiology	Expand lab and radiology using vacant space to meet CARES workload projections.	2007	\$1,680,000
4,5,6,13	-	Bedford	All Other	VISN 1-Bedford-2007-8	Renovate Bldg 78 for Specialty Care Clinics	Renovate Bldg 78 for Specialty Care Clinics	2007	\$2,329,000
13	-	Bedford	All Other	VISN 1-Bedford-2007-9	Renovate Bldg 8	Asbestos removal, halls/walls and other upgrades	2007	\$4,315,000
1,4,5,14,15	-	Boston	All Other	VISN 1-Boston-2007-10	Linear Accelerator Site Prep	Project required to install Linear Accelerator equipment	2007	\$800,000
5,11,13	-	Boston	All Other	VISN 1-Boston-2007-	Infrastructure Improvements, JP,	Electrical and Mechanical	2007	\$1,900,000

VISN 1 Stage 2 Strategic Plan FY2006 – 2010

				6	PH 2	Upgrades to support future renovations		
13	-	Boston	All Other	VISN 1-Boston-2007-1	Administration Renovation	Renovations: B1, Engineering and Environmental Management	2007	\$780,000
1,3,4,5,6,11	-	Boston	All Other	VISN 1-Boston-2007-3	Specialty Care Clinics/OP Pharmacy	Renovate the first floor of Building 1 to accommodate the OP pharmacy and additional specialty care space.	2007	\$1,410,000
1,3,4,5,6	-	Boston	All Other	VISN 1-Boston-2007-5	Specialty Care Renovate/GI Clinic	Conversion of vacant space in Bldgs 1 and 9 for specialty care expansion.	2007	\$1,200,000
1,2,3,4,5,6	-	Brockton	All Other	VISN 1-Brockton-2007-5	Primary Care Expansion	Expand primary care using vacant space.	2007	\$2,500,000
4,5,6,13	-	Brockton	All Other	VISN 1-Brockton-2007-1	Dental Renovation	Renovate Bldg 3, 2nd floor for Dental.	2007	\$850,000
1,2,4,5,6	-	Brockton	All Other	VISN 1-Brockton-2007-2	Mental Health Renovations	Outpatient mental health renovations.	2007	\$3,960,000
1,2,3,4,5,6	-	Brockton	All Other	VISN 1-Brockton-2007-4	Specialty Care Expansion	Specialty care expansion in Bldg 3, 4th floor	2007	\$2,750,000
4,5,6,13	-	Manchester	All Other	VISN 1-Manchester-	Specialty Care Addition	Add third floor to Bldg 15 for specialty	2007	\$4,651,500

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				2007-4		care clinics.		
4,5,6,8	-	Manchester	All Other	VISN 1- Manchester- 2007-10	MRI Site Prep	Project required to install MRI equipment	2007	\$1,150,000
2,5,6,7,13	-	Northampton	All Other	VISN 1- Northampton- 2007-2	Inpatient Psychiatry Renovation	Patient privacy and infrastructure improvements to inpatient psychiatry. Elimination of Cherry Street Res Rehab space; bring in-house to vacant space.	2007	\$7,000,000
5,6,7,13	-	Northampton	All Other	VISN 1- Northampton- 2007-1	Elevator, B-4	Replace and upgrade elevators in Building 4	2007	\$1,600,000
3,4,5,13	-	Providence	All Other	VISN 1- Providence- 2007-17	Rehab Ward 3 A	This project is new to the five year plan. The overall specialty clinic gap of 38,720 SF is addressed in this project.	2007	\$2,542,199
2,4,5,6,13	-	Providence	All Other	VISN 1- Providence- 2007-11	Psychiatry Ward Renovation/Convert Vacant	Renovate and consolidate psychiatry wards	2007	\$3,995,450
4,5,6,13	-	Providence	All Other	VISN 1- Providence- 2007-12	Expand Pharmacy	Move Pharmacy to 1A & construct new building for displaced admin.	2007	\$5,115,025
4,5,6,13	-	Providence	All Other	VISN 1- Providence-	OR Addition	This project is new to the five year plan.	2007	\$6,715,800

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				2007-15		It addresses the 10,614 SF CARES gap. Addition of OR suite to replace 1950s-era OR and to meet CARES projections		
4,5,6,13	-	Providence	All Other	VISN 1-Providence-2007-13	Expand Emergency Room	This project is new to the five year plan; it addresses the CARES gap and JCAHO findings of inadequate space.	2007	\$3,624,330
4,5,6,8	-	Providence	All Other	VISN 1-Providence-2007-9	MRI Site Prep	Project required to install MRI equipment	2007	\$1,599,000
4,5,6,8	-	Providence	All Other	VISN 1-Providence-2007-10	Cardiac Catheterization Site Prep	Project required to install Cardiac Cath equipment	2007	\$1,000,000
1,4,5,6,10,13	-	Providence	All Other	VISN 1-Providence-2007-1	Specialty Clinics Addition	Specialty clinics addition to address CARES gaps	2007	\$5,136,768
5,7,13,15	-	Togus	All Other	VISN 1-Togus-2007-5	Nursing Home Renovation	Upgrade and improve the existing HVAC system. Current system is inappropriately designed for a modern nursing home setting. The system requires substantial	2007	\$5,500,000

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						monitoring during change over seasons. Also included will be associated interior improvements. Modifications to the inner space will be required to accommodate the new equipment. This project has the potential of installing more efficient HVAC units thus differing some utility costs and potential payback.		
4,5,6	-	Togus	All Other	VISN 1-Togus-2007-7	Construct Specialty Care Clinic, B200E	Convert existing vacant space in B200E, 2 floor	2007	\$1,633,742
5,7,15	-	Togus	All Other	VISN 1-Togus-2007-6	Upgrade HVAC, B203/204	Add HVAC to unventilated buildings. HVAC equipment will be energy efficient to maximize cost deferment.	2007	\$3,300,000
4,5,6	-	Togus	All Other	VISN 1-Togus-2007-10	MRI Site Prep	Project required to install MRI equipment	2007	\$1,750,000
2,4,5,6	-	Togus	All Other	VISN 1-Togus-2007-	Psych Unit, B206	Renovate and upgrade B206 for	2007	\$1,807,500

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				4		Psychiatry Has potential of reducing vacant space		
4,5,6,9,10,13	-	West Haven	All Other	VISN 1-West Haven-2007-2	Specialty Care Ph I	Renovate Building 1 & 2 for specialty care.	2007	\$5,590,125
5,9,13	-	West Haven	All Other	VISN 1-West Haven-2007-5	Research Renovation Ph II	Renovate Building 2 for research activities. Design approved for FY 05, but FY 06 construction funding is suspect. Carrying project for FY 07 resubmission.	2007	\$4,906,000
4,5,15	-	West Haven	All Other	VISN 1-West Haven-2007-3	Support Area Reno Dietetics/Lab	Renovation of support areas	2007	\$4,800,000
5,11,13	-	West Roxbury	All Other	VISN 1-West Roxbury-2007-3	Infrastructure Improvements (WR) PH 2	Electrical and Mechanical Upgrades to support future renovations	2007	\$1,900,000
1,4,5,6,13	-	White River Junction	All Other	VISN 1-White River Junction-2007-2	Specialty Care Addition	Adds third floor to Bldg 39 and replaces HVAC system.	2007	\$6,084,700
4,5,6,8	-	White River Junction	All Other	VISN 1-White River Junction-2007-10	MRI Site Prep	Project required to install MRI equipment	2007	\$1,785,000
		All Other - 2007 Total						\$110,987,139

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9,10,13	-	Bedford	Research	VISN 1-Bedford-2007-5	Renovate Bld 19 for ARF	Expand and upgrade animal research facility.	2007	\$4,063,000
9,10,13	-	Bedford	Research	VISN 1-Bedford-2007-6	Renovate Bld 17 Research	Renovate Building 17 for Research	2007	\$3,883,000
1,3,9,10,13	-	Boston	Research	VISN 1-Boston-2007-2	Animal Research Improvements, B1-A	Renovate two floors of Bldg 1-A to improve animal rooms, OR, wet labs and replace HVAC system and upgrade elevator.	2007	\$2,450,000
9,13	-	Providence	Research	VISN 1-Providence-2007-4	Research Facility	Expansion and renovation of existing research building	2007	\$6,598,000
9,10	-	West Haven	Research	VISN 1-West Haven-2007-4	Research Phase 3	Convert to wet lab space	2007	\$4,129,100
1,5,9,10,11,12,13	-	West Roxbury	Research	VISN 1-West Roxbury-2007-1	Replacement Research Buildings	Demolish existing research buildings and replace with new state-of-the art buildings.	2007	\$3,200,000
Research - 2007 Total								\$24,323,100
VISN 1 - 2007 Total								\$135,310,239
2,4,5,6,13	-	Bedford	All Other	VISN 1-Bedford-2008-2	Renovate Domiciliary	Renovate Bldg 6 for relocation of Domiciliary to address poor	2008	\$1,259,000

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						condition codes.		
5,11,13	-	Boston	All Other	VISN 1- Boston-2008-4	Infrastructure Improvements, JP, PH 3	Electrical and Mechanical Upgrades to support future renovations	2008	\$4,500,000
1,3,4,5,6,11,12,13	-	Boston	All Other	VISN 1- Boston-2008-1	Support Service Modification (JP) Ph 2	Renovations to support multiple space relocations.	2008	\$1,347,500
4,5,6,7,13	-	Manchester	All Other	VISN 1- Manchester-2008-2	Specialty Care Renovations	Renovations of Audiology, Optometry and other specialty clinics.	2008	\$2,650,500
2,4,5,6,13	2,3,8	Manchester	All Other	VISN 1- Manchester-2008-3	Mental Health Additions and Improvements	Renovations to mental health clinics. Construct 18 Bed Long Term Psych and a 15 bed Substance Abuse CWT/TR	2008	\$6,700,000
2,4,5,6,7,13	-	Northampton	All Other	VISN 1- Northampton-2008-2	Outpatient Mental Health Renovations	Renovate building 9 for outpatient mental health.	2008	\$6,000,000
4,5,6,13	-	Northampton	All Other	VISN 1- Northampton-2008-1	Nursing Home Renovation and Expansion	Renovation of NH space and expansion of 30-beds using vacant space.	2008	\$6,000,000
4,5,6	-	Providence	All Other	VISN 1- Providence-2008-2	Rehab Medicine Addition	This project is new to the five year plan. The goal of this project is to provide	2008	\$2,244,836

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						the 6,500 SF of space identified by CARES.		
1,4,5,6	-	Providence	All Other	VISN 1-Providence-2008-5	Medicine Convert Space	Re-activation of closed inpatient ward to meet projected inpatient medicine demand.	2008	\$1,249,897
4,5,6,13	-	Providence	All Other	VISN 1-Providence-2008-16	Renovate FIRM 6	This project is new to the five year plan. This area of the hospital is overdue for renovation.	2008	\$2,244,088
2	2,3,8	Togus	All Other	VISN 1-Togus-2008-8	Construct 25 Bed Dom	Construct a new Dom unit at the Togus campus. project is based upon Stage 2 Strategic Planning	2008	\$2,682,328
4,5,6,13	-	Togus	All Other	VISN 1-Togus-2008-7	Hospice Unit, B207-1	Construct hospice unit in building 207	2008	\$3,500,000
5,7,15	-	Togus	All Other	VISN 1-Togus-2008-1	Upgrade HVAC, B209/210	Add HVAC to unventilated buildings.	2008	\$2,860,000
5,6,7	-	Togus	All Other	VISN 1-Togus-2008-2	Private, Semi-private Baths, B200, Phase 1	Private - Semi-private Bathrooms B200, 3N	2008	\$6,600,000
4,5,6,9,10,13	-	West Haven	All Other	VISN 1-West Haven-2008-10	MRI Site Prep	Project required to install MRI equipment	2008	\$1,500,000

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4,5,6,9,10,13	-	West Haven	All Other	VISN 1-West Haven-2008-2	Specialty Care Ph. II	Renovate building 1 & 2 for specialty care	2008	\$4,200,000
3,4,5,6,9,10,13	-	West Haven	All Other	VISN 1-West Haven-2008-1	ICU Renovation	ICU Renovation	2008	\$4,200,000
5,11,13	-	West Roxbury	All Other	VISN 1-West Roxbury-2008-4	Infrastructure Improvements (WR) PH 3	Electrical and Mechanical Upgrades to support future renovations	2008	\$1,200,000
1,4,5,14,15	-	West Roxbury	All Other	VISN 1-West Roxbury-2008-5	MRI Cardiac Imaging Site Prep	Project required to install MRI equipment	2008	\$2,500,000
1,4,5,14,15	-	West Roxbury	All Other	VISN 1-West Roxbury-2008-1	EP Lab Site Prep	Project required to install EP Lab equipment	2008	\$500,000
1,3,4,5,6,11	-	West Roxbury	All Other	VISN 1-West Roxbury-2008-2	Medical Nursing Unit B1-4N	Expand inpatient medicine to accommodate workload shifts from Brockton, JP and Bedford. Includes relocating Endoscopy to make SF available for inpatient medicine.	2008	\$4,550,000
2	2,3,8	White River Junction	All Other	VISN 1-White River Junction-2008-3	Construct 15 Bed Substance Abuse Res Rehab	Construct a 15 bed building for Substance Abuse Residential Rehab	2008	\$2,500,000
1,4,5,6,13	-	White River Junction	All Other	VISN 1-White River	Specialty Care Renovations	Renovate existing space once the	2008	\$3,789,000

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				Junction-2008-2		Specialty Care Addition to Bldg 39 is completed.		
All Other - 2008 Total								\$74,777,149
9,13	-	Bedford	Research	VISN 1-Bedford-2008-3	Renovate Bldg 17, 18, 70	Asbestos removal, halls/walls and other upgrades	2008	\$5,500,000
1,5,9,10,11,12,13,15	-	Boston	Research	VISN 1-Boston-2008-3	Research Facility Renovation B1-A	Renovation of wet lab in B1, floors 1-3.	2008	\$3,450,000
1,2,5,9,10,11,12,15	-	Brockton	Research	VISN 1-Brockton-2008-2	Replacement Research Facility B44, B46	Replacement of Bldgs 44 and 46 with new buildings to meet current standards.	2008	\$2,450,000
Research - 2008 Total								\$11,400,000
VISN 1 - 2008 Total								\$86,177,149
2,4,5,6,13	-	Bedford	All Other	VISN 1-Bedford-2009-1	Renovation Outpatient Mental Health	Renovate building 7 for outpatient mental health clinics upon relocation of Domiciliary.	2009	\$3,881,000
1,4,5,6	-	Bedford	All Other	VISN 1-Bedford-2009-4	Renovate Bldg 5 for Specialty Care	Renovate Bldg 5 for Specialty Care	2009	\$5,744,000
13	-	Bedford	All Other	VISN 1-Bedford-2009-6	Renovate Bldg 9	Asbestos removal, halls/walls and other upgrades	2009	\$5,585,000
4,5,6,8,13	-	Bedford	All Other	VISN 1-Bedford-2009-11	MRI Site Prep	Project required to install MRI equipment	2009	\$1,049,000

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1,4,5,14,15	-	Boston	All Other	VISN 1- Boston-2009-8	Pet Scan Site Prep	Project required to install PET equipment	2009	\$1,000,000
1,4,5,14,15	-	Boston	All Other	VISN 1- Boston-2009-11	Cyclotron Site Prep	Project required to install Cyclotron equipment	2009	\$2,500,000
1,3,4,5,6	-	Boston	All Other	VISN 1- Boston-2009-1	Eye Clinic	Consolidate Eye Clinic	2009	\$1,900,000
4,5,6,13	-	Manchester	All Other	VISN 1- Manchester-2009-4	Ancillary/Diagnostic Renovations	Renovate Radiology and Clinical Lab.	2009	\$2,895,000
7,13	-	Manchester	All Other	VISN 1- Manchester-2009-1	Administration Renovation 1	Renovations to HRM, Fiscal and A&MM due to condition codes	2009	\$3,950,000
2,3,9,12	-	Newington	All Other	VISN 1- Newington-2009-2	Renovate Dental/Eye Clinic/Rec Ther	Renovate Dental, Eye, and Recreation Therapy	2009	\$870,000
3,4,5,6,9,10,13	-	Newington	All Other	VISN 1- Newington-2009-3	Renovate Ancillary/Diagnostic	Renovate Ancillary/Diagnostic	2009	\$1,406,700
5,13	-	Northampton	All Other	VISN 1- Northampton-2009-1	Renovate Recreation Therapy	Renovate Recreation Therapy	2009	\$1,500,000
5,6,13	-	Northampton	All Other	VISN 1- Northampton-2009-2	Rehab Medicine Renovation	Renovation of basement Bldg 1 for Rehab Medicine due to poor condition codes.	2009	\$1,000,000
4,5,6,13	-	Providence	All Other	VISN 1-	Renovate Dental	Renovate Dental	2009	\$2,459,645

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				Providence-2009-2		space to meet space and functional criteria		
4,5,6	-	Providence	All Other	VISN 1-Providence-2009-1	Angio Site Prep	Site prep for angio equipment	2009	\$500,000
2	2,3,8	Togus	All Other	VISN 1-Togus-2009-4	Substance Abuse Residential Rehab	Construct 25 bed Substance Abuse Residential Rehab Unit	2009	\$3,500,000
5,6,7	-	Togus	All Other	VISN 1-Togus-2009-1	Private, Semi-private Baths, B200, Phase 2	Private - Semi-private Bathrooms B200, 4S	2009	\$3,300,000
4,5,6	-	Togus	All Other	VISN 1-Togus-2009-2	Private Baths NH Phase I	Private Baths for Nursing Home Units	2009	\$6,600,000
4,5,15	-	West Haven	All Other	VISN 1-West Haven-2009-2	Inpatient Pharmacy Renovation	Building 1 Inpatient Pharmacy and Hoptel renovations	2009	\$1,500,000
4,5,6,9,10,13	-	West Haven	All Other	VISN 1-West Haven-2009-3	Primary Care Renovations	Renovate floor 3 in Bldg 2 for primary care. Eliminates need for additional leased space.	2009	\$1,750,000
2,4,5,6,9,10,13	-	West Haven	All Other	VISN 1-West Haven-2009-4	Mental Health Renovations Phase I	Substance Abuse Clinic, Building 1, 8E	2009	\$1,820,000
2	2,3,8	West Haven	All Other	VISN 1-West Haven-2009-5	Construct 25 Bed Dom	Construct a 25 Bed Dom Unit	2009	\$3,343,192
1,3,4,5,6,11	-	West	All Other	VISN 1-West	Surgical Nursing	Expand inpatient	2009	\$4,000,000

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		Roxbury		Roxbury-2009-3	Unit, B1-3N	surgery to accommodate workload shifts from Brockton, JP and Bedford.		
1,3,4,5,6,11,12,13	-	West Roxbury	All Other	VISN 1-West Roxbury-2009-2	Support Service Modification (WR) Ph 3	Renovate pharmacy space.	2009	\$1,500,000
4,5,6,13	-	White River Junction	All Other	VISN 1-White River Junction-2009-1	Nuclear Medicine and MRI	Renovate space for Nuclear Medicine and add space for MRI.	2009	\$5,000,000
7,13	-	White River Junction	All Other	VISN 1-White River Junction-2009-3	Administrative Renovations	Renovate buildings 6 and 7 and other administrative space	2009	\$870,000
4,5,6,8	-	White River Junction	All Other	VISN 1-White River Junction-2009-10	Pet Scan Site Prep	Project required to install PET equipment	2009	\$1,500,000
4,5,6,7,13	-	White River Junction	All Other	VISN 1-White River Junction-2009-2	Inpatient Ward Renovation	Renovate existing ward space to increase beds.	2009	\$4,597,000
All Other - 2009 Total								\$75,520,537
9	-	Bedford	Research	VISN 1-Bedford-2009-10	Pet Scan Site Prep - Research	Project required to install PET equipment	2009	\$1,049,000
1,2,5,9,10,11,12,15	-	Brockton	Research	VISN 1-Brockton-2009-3	New Nitrogen/Cryogenics Facility, B25	Renovate Bldg 25 to create a new Nitrogen/Cryogenics	2009	\$1,320,000

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						Facility.		
9,10,13	-	White River Junction	Research	VISN 1-White River Junction-2009-4	Research Renovations	Renovates existing Research space. Adds a new roof and resolves numerous HVAC issues.	2009	\$2,684,000
		Research - 2009 Total						\$5,053,000
VISN 1 - 2009 Total								\$80,573,537
13	-	Bedford	All Other	VISN 1-Bedford-2010-2	Renovate Bldg 1	Elevator installation, asbestos, halls/walls and other upgrades	2010	\$2,020,000
7,13	-	Manchester	All Other	VISN 1-Manchester-2010-5	Administration Renovation 2	Renovations to MCCF, Voluntary, Dietetic Offices, Business Office due to condition codes	2010	\$2,950,000
4,5,6,13	-	Manchester	All Other	VISN 1-Manchester-2010-6	Renovate Pharmacy, Dental	Renovate Pharmacy and Dental due to condition codes.	2010	\$1,850,000
4,5,6,9,10,13	-	Newington	All Other	VISN 1-Newington-2010-4	Expand Primary Care	Expand primary care using vacant space.	2010	\$516,000
5,6,7,13	-	Northampton	All Other	VISN 1-Northampton-2010-1	Central Chiller Plant	Install Central Air Conditioning Chill Water Plant with pipe loop to all buildings. Tie in existing chill water air handlers and	2010	\$5,000,000

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						remove old equipment.		
5,7,13	-	Northampton	All Other	VISN 1-Northampton-2010-2	Elevators Building 11 & 25	Replace and upgrade elevator service in Building 11 & 25.	2010	\$1,500,000
8,10,13	-	Northampton	All Other	VISN 1-Northampton-2010-3	Renovate Education Space	Renovate Education Space, Bldg 25	2010	\$1,100,000
2,4,5,6	-	Providence	All Other	VISN 1-Providence-2010-6	Mental Health Renovations	Renovation of outpatient Mental Health space	2010	\$2,198,000
5,13	-	Providence	All Other	VISN 1-Providence-2010-1	Expand SPD	Renovate 3C to expand SPD	2010	\$1,163,835
2	2,3,8	Togus	All Other	VISN 1-Togus-2010-4	Construct 25 Bed Sub Abuse CWT/TR	Purchase land and construct a 25 bed substance abuse CWT/TR in Portland, ME	2010	\$4,500,000
4,5,6	-	Togus	All Other	VISN 1-Togus-2010-2	Private Baths NH Phase 2	Private Baths for Nursing Home Units	2010	\$6,600,000
7,13	-	Togus	All Other	VISN 1-Togus-2010-3	Administration Renovation	Halls and walls, B203, with alterations to OM.	2010	\$1,650,000
4,5,6,9,10,13	-	West Haven	All Other	VISN 1-West Haven-2010-3	Blind Rehab Renovations	Renovate Blind Rehab space Bldg 1 floor 4	2010	\$4,300,000
1,2,4,5,6,9,10,13	-	West Haven	All Other	VISN 1-West Haven-2010-	Intermediate, Nursing Home	Project is required to renovate nursing	2010	\$4,666,360

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				1	Renovation	home beds at the West Haven Campus		
4,5,6,9,10,13	-	West Haven	All Other	VISN 1-West Haven-2010-2	Renovate Primary Care	Renovate the primary care clinics at West Haven	2010	\$1,315,860
All Other - 2010 Total								\$41,330,055
VISN 1 - 2010 Total								\$41,330,055
2,4,5,6,13	-	Bedford	All Other	VISN 1-Bedford-2011-2	Renovate Pharmacy and Recreation Therapy	Renovate Pharmacy and Recreation Therapy	2011	\$3,120,000
13	-	Bedford	All Other	VISN 1-Bedford-2011-3	Renovate Bldg 80,81,82	Asbestos removal, halls/walls and other upgrades	2011	\$4,823,000
4,5,6,9,10,13	-	Newington	All Other	VISN 1-Newington-2011-1	Expand Specialty Care	Expand Specialty Care using vacant space	2011	\$2,850,900
2,4,5,6,9,10,13	-	Newington	All Other	VISN 1-Newington-2011-2	Renovate for Mental Health	Renovation of mental health area.	2011	\$2,036,450
2,5,6,7,13,15	-	Northampton	All Other	VISN 1-Northampton-2011-1	Air Condition Buildings	Air condition buildings 1, 2, 3, 4, 6, 8, 11, 12, 20, 25, 60. Remove 350 window a/c units.	2011	\$6,000,000
5,6,7,13	-	Northampton	All Other	VISN 1-Northampton-2011-2	Elevators Bldg 20	Replace and upgrade elevators for building 20	2011	\$1,000,000
2,4,5,6,9,10,13	-	West Haven	All Other	VISN 1-West Haven-2011-1	Mental Health Renovations Phase 2	Mental Health Clinic, Building 1, 7W	2011	\$1,690,000

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		All Other - 2011 Total						\$21,520,350
9,10,13	-	Bedford	Research	VISN 1- Bedford- 2011-1	Renovate Research Space	Renovate research space in buildings 17, 18 to address condition codes	2011	\$3,560,000
			Research - 2011 Total					\$3,560,000
VISN 1 - 2011 Total								\$25,080,350